MEDICARE FRAUD, WASTE, AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

JUNE 13, 1991

Serial 102-62

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

49-774 WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-037758-7

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MEDICARE FRAUD, WASTE, AND ABUSE

THURSDAY, JUNE 13, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing and background material follow:]

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 4, 1991

PRESS RELEASE #13
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
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THE HONORABLE FORTNEY PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON MEDICARE FRAUD, WASTE AND ABUSE

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on Medicare fraud, waste and abuse. This hearing is part of the full Committee's oversight initiative on the efficiency and policy effectiveness of programs in the Committee's jurisdiction. The hearing will be held on Thursday, June 13, 1991, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Stark stated, "While Medicare does a better job of controlling costs than any other health insurance plan in the United States, Congress must insure that all possible efforts are made to eliminate fraud and abuse."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

Four organizations with responsibility for identifying fraud, waste and abuse in Medicare include: the Office of the Inspector General in the Department of Health and Human Services; Medicare fiscal intermediaries and carriers; Professional Review Organizations (PROs); and the General Accounting Office (GAO).

The Department of Health and Human Services Inspector General (IG) has responsibility for oversight of programs within the Department, including Medicare. The IG oversees departmental management activities, and makes recommendations to the Congress and the Administration that would make more appropriate use of program expenditures through cost avoidances and budget savings. In addition, the IG has primary responsibility for pursuing violations of certain Medicare rules through civil monetary penalties, recoupments and other forms of settlements.

The Medicare fiscal intermediaries and carriers are private insurance companies who process 670 million Medicare claims annually under contract with the Health Care Financing Administration (HCFA). In addition, these entities have responsibility for a variety of payment safeguard activities, including pre- and post-payment reviews of claims and administration of the Medicare Secondary Payer program.

PROs conduct certain utilization and quality-of-care reviews under contract with HCFA. To date, PRO review has primarily focused on overseeing the introduction of the Medicare hospital diagnostic-related group (DRG) payment system through reviews of hospital admissions. In response to identified problems, PROs are authorized to initiate a variety of interventions ranging from continuing education, denials of payments, and other sanctions.

(MORE)

GAO is a non-partisan agency in the legislative branch established to independently audit and evaluate Federal programs. Last year, out of concern for recent scandals, GAO initiated an effort to target certain high-risk government programs. Medicare is one of the programs where GAO believes there may be a risk of large losses through mismanagement, waste and abuse.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, June 27, 1991, to Robert J. Leonard, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. Good morning. The Subcommittee on Health of the Committee on Ways and Means will begin hearing issues relating to Medicare fraud, waste, and abuse. This is part of the committee's oversight initiative on the efficiency and effectiveness of programs within our jurisdiction.

Today's hearing is a focused examination of detailed issues and policies relating to the Medicare program.

When a program spends $120 billion a year, there are likely to be loopholes. There are an awful lot of bright folks out there who see opportunities to line their own pockets at taxpayers' expense. We understand that and it is our job to see if we can find those loopholes and close them.

This morning we will hear from the Honorable Charles Bowsher, the Comptroller General of the United States, and the Honorable Richard Kusserow, the Inspector General of the U.S. Department of Health and Human Services. These gentlemen, and the agencies they direct, have the primary responsibility of identifying fraud, waste, and abuse in the Medicare program.

There are two primary issues relating to fraud, waste, and abuse: First, are there specific policies that result in Medicare paying more than it should for certain services? Or is Medicare paying for services that provide no real benefit for patients? And second, and perhaps more important issue, is whether we have adequate administrative structures in place to insure that public funds are being properly spent. Or, in fact, to deter scam artists from even trying to get money they are not entitled.

I am very concerned about the level of support that is currently given to fiscal intermediaries and carriers. Over the past 10 years, the administrative budget for Medicare has been under constant attack by the Reagan and Bush administrations in an effort to reduce both the Federal budget and Government regulation.

Controlling fraud, waste, and abuse is not "over-regulation." It is the basic process that assures taxpayers that their money is being well spent. These activities deserve our strong support. We can't expect the public to support Medicare expansions if we allow the system to be ripped off, and we waste scarce financial resources.

With this in mind, I am pleased to announce today the release of a major new report from the GAO, summarizing all of its work over the past year. I understand that the Inspector General has also prepared a new report—being released today—summarizing the work that has been carried out within the Department.

Both reports contain numerous recommendations, ranging from possible improvements in reimbursement policies to evaluation of the effectiveness of payment safeguard activities.

While this committee may not agree with all of the findings and recommendations in these reports, the reports will be used by the subcommittee to insure that Medicare funds are being properly spent.

Mr. Gradison.

Mr. GRADISON. I have no statement, thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Mr. Chairman, thank you for holding this important hearing. Last year we had the opportunity to examine problems in the area of cataract surgery, an area which drew a great deal of

attention in Michigan and elsewhere. This year in addition to Medicare waste, fraud and abuse we are looking at possible abuses in other specific areas.

It is important that we pay close attention to fraud and abuse in the Medicare area because beneficiaries are often incapable of determining when necessary and appropriate care is being provided.

Last year several of us proposed strengthening fraud and abuse laws. These changes would not only have been applicable to abuses in the cataract surgery but to fraud and abuse in other areas. These provisions were embraced in the House. Unfortunately they did not make it through the entire Congress into law. This year this issue is again receiving a great deal of attention, as it must.

This is not an issue that exists in isolation to the Medicare program. As we discuss various options for reforming the health care system the potential for fraud, waste, abuse and inefficiency must be considered and addressed.

I commend the chairman, indeed the entire committee and staff for having this hearing. I look forward to continuing our work on this vital issue.

Chairman STARK. Would any other members like to offer opening statements? If not, it is my pleasure to welcome the Comptroller General of the United States, the Honorable Charles Bowsher. He is accompanied by Janet Shikles, Director of Health Financing and Policy Issues, Edwin Stropko, Associate Director, National and Public Health Issues, and Thomas G. Dowdal, Associate Director of Health Financing and Policy Issues.

I want to welcome the Comptroller General back to the subcommittee. I would like to thank you particularly for the report being released today as well as for all the work you have done for this subcommittee over the years. I want to make it clear that I have not asked you or your Department to go anywhere near the Persian Gulf or Central America on behalf of this subcommittee. All your work has been done in North America.

I also want to thank all of the witnesses testifying today. Your written testimony will be made part of the permanent record of the subcommittee. You may proceed to summarize your statements or elaborate on them in any manner you are comfortable with.

STATEMENT OF HON. CHARLES A. BOWSHER, COMPTROLLER GENERAL, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY JANET SHIKLES, DIRECTOR OF HEALTH FINANCING AND POLICY ISSUES; EDWIN STROPKO, ASSOCIATE DIRECTOR, NATIONAL AND PUBLIC HEALTH ISSUES; AND THOMAS G. DOWDAL, ASSOCIATE DIRECTOR OF HEALTH FINANCING AND POLICY ISSUES

Mr. BOWSHER. Thank you, Mr. Chairman.

I have put a summary statement together of only five pages. I would like to read that and have the full statement put in the record.

Chairman STARK. Without objection.

Mr. BOWSHER. We are pleased to be here today to discuss actions that need to be taken to control rising Medicare costs. Early this

year I appeared before the full committee to discuss broad strategies to control national health care expenditures.

Since 1980 health spending has been the second fastest growing component of the Federal budget trailing only interest expense on the national debt. During the last decade Medicare has been consuming a larger portion of the Federal health care dollar. Subsequently, an important step in getting the federal budget under control is to get Medicare spending under control.

I will be focusing first on changes to Medicare payment methods that will reduce spending and then on ways to improve program administration to help minimize losses due to waste, fraud and abuse. My comments and the report we are releasing today draw on our work identifying areas where over $1 billion of savings can be achieved and include a recommendation on how to ensure better administration of Medicare.

Congressional actions over the last decade have resulted in major reforms in the way Medicare pays hospitals and physicians. Yet as the subcommittee is aware, much remains to be done to insure that these reforms realize their full potential.

One area of concern is continuing overpayment for diagnostic services. We have recently reported that Medicare payment rates for clinical diagnostic lab services remain excessive. The five largest laboratories participating in the Medicare program had profits on Medicare business that were 11 percent higher than their overall profit rates. Reducing Medicare payments for these services by an amount that would eliminate the profit rate disparity could save us about $150 million annually.

Another issue involves how Medicare pays for emerging technology. We are concerned that Medicare payment rates established for new technologies are not systematically and periodically adjusted down as the technology ages and unit costs decline. Failing to make the adjustments results in high Medicare payments and encourages an oversupply of the equipment because profits can be earned in inefficient levels of operations. We are developing a method that might be considered to make such adjustments and will report to you later this year.

The recently adopted resource based physician payment system provides opportunities to bring the most rapidly growing segment of Medicare costs under control. In my earlier testimony before the full committee, I cited spending targets for major health care sectors as being used in other countries successfully. We believe the implementation of the Medicare physician reforms is important not only to control Medicare costs but as a possible model for reforming physician payments overall.

Along with the changes in Medicare payments to control costs program administration must be improved to assure that Medicare pays appropriately for services that beneficiaries receive. In a series of ongoing reviews we are finding that program dollars are not being protected adequately. We believe that part of this mismanagement is attributed to budget cutbacks in program administration.

Although Medicare payment safeguard activities are cost effective, returning $14 for every $1 spent, contractor budgets to perform these functions have been cut each year since 1989. Most re-

cently, the administration requested $333 million for fiscal year 1992 for program safeguard activities, less than the amount spent in 1989, while projecting a 40-percent increase in the number of claims contractors will process.

In 1990, total savings forgone as a result of the reduction in Medicare safeguard activities were estimated at nearly $500 million. Funding reductions have caused contractors to cut back on medical utilization reviews and other activities useful for protecting against erroneous or fraudulent payments. Contractors also cite a lack of funding for not collecting hundreds of millions of dollars owed to Medicare by private insurers.

We believe that there is room for improvement in the efficiency and effectiveness of Medicare contractor operations. Over the years we have reviewed and addressed shortcomings in contractor payments safeguard activities. We will also be issuing a series of reports on this issue starting later this year. HCFA, likewise has concerns about the existing administrative structure and has undertaken a Medicare contract to reform initiatives to address these issues.

At least until other reforms are implemented, funding cutbacks in areas like program safeguards will likely cost more than they save. We believe the solution lies in adequately funding these important contractor functions.

The way the IRS compliance activities are funded serves as an instructive funding model. Under the Budget Enforcement Act of 1990 the Congress voted for increased IRS activities without necessitating spending cuts elsewhere. We recommend the Congress find a similar method for Medicare activities. The result would be a significant net reduction in Medicare costs.

Mr. Chairman, this concludes our statement. We will be pleased to answer any questions that you have.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF CHARLES A. BOWSHER, COMPTROLLER GENERAL OF THE UNITED STATES

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss actions needed to control rising Medicare costs. Earlier this year I appeared before the full committee to discuss broad strategies to control national health care spending. Today, I will focus on specific steps to address Medicare's cost growth.

To underscore the importance of today's discussion, I would like to put the growth of health spending in the context of the federal budget problem. Since 1980, health spending has been the second fastest growing component of the federal budget, trailing only interest expense on the burgeoning national debt. As federal health outlays have risen, Medicare has increased its budgetary importance and is consuming larger portions of the federal health care dollar. Even after adjusting for increases in beneficiaries, Medicare costs are still growing faster than general inflation or the gross national product. Consequently, an important step in getting the federal budget under control is to get Medicare spending under control.

Therefore, I will be focusing today first on changes to Medicare payment methods that will reduce program spending and then on ways to improve program administration to help minimize program losses due to waste, fraud, and abuse. My comments and the report we released today, *Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs* (GAO/HRD-91-67), draw on GAO's work identifying areas for over $1 billion in savings and include a recommendation on how to ensure better program administration.

OPPORTUNITIES TO REDUCE MEDICARE PAYMENTS TO PROVIDERS

Congressional actions over the last decade have resulted in major reforms in the way Medicare pays hospitals and physicians. The adoption of a prospective payment system (PPS) for hospitals and comprehensive physician payment reform were two bold steps providing Medicare with a framework for effective cost containment. Indeed, in our work looking at several other countries' health care systems, we have found that PPS is being considered as a model for their reform efforts. Yet, as the Subcommittee is aware, much remains to be done to ensure that these reforms realize their full potential.

Growth in Medicare spending has accelerated each year since 1986. In 1989, Medicare expenditures increased nearly 13 percent over spending in 1988—exceeding the 11-percent growth in the nation's total spending for health care. The Congressional Budget Office projects that over the next 5 years Medicare outlays will increase nearly 70 percent—from $105 to $177 billion.

Looking further into the future, the Medicare trustees project that the Hospital Insurance Trust Fund will be depleted in about 15 years. Further, the rapid growth in physician-related expenditures, if left unchecked, will place an increasing burden on both the federal budget and beneficiaries whose Medicare premiums are currently structured to offset 25 percent of these expenditures. Consequently, much of our work has been and will continue to be focused on identifying ways to reduce or refine Medicare payment amounts and methods. I will give a few examples of areas we have identified where action is needed.

One area of concern is continued overpayment for diagnostic services. We have found, for example, that Medicare payment rates for clinical diagnostic laboratory services remain excessive. Despite recent fee reductions, the five largest laboratories participating in the Medicare program had profits on Medicare business that were 11 percent higher than their overall profit rates. In effect, Medicare was subsidizing other laboratory customers. Reducing Medicare payments for clinical laboratory services by an amount that would eliminate this profit rate disparity could save Medicare about $150 million annually.

Another issue involves how Medicare pays for emerging technology. The rapid development and increased use of new medical technologies is widely acknowledged as a key factor driving health care cost inflation. In the United States, the diffusion of new medical technology is relatively unrestrained once it is declared eligible for Medicare reimbursement.

As the new technology matures, reductions in equipment costs, improvements in its efficiency, and increased utilization can decrease unit costs. Medicare payment rates established for technology when it is new, however, are not systematically adjusted downward as the technology ages and unit costs decline. Failing to make such adjustments results in unnecessarily high Medicare payments and encourages an oversupply of the equipment because profits can be earned at inefficient levels of operation. We are developing a method that might be considered to make such adjustments.

The prospective payment system for hospitals is another area that requires continuing attention. For PPS to remain a factor in containing hospital cost growth, payment rates must be closely monitored to assure that they remain appropriate relative to hospitals' costs and that they provide incentives for efficient operations. Payments to teaching hospitals are one area where we believe payments have been and remain excessive.

Our work and that of others has shown that Medicare substantially overcompensates teaching hospitals for the indirect costs they incur as a result of their teaching programs. Our best estimate is that such payments should be reduced by about a third, which would have been about $840 million in 1990, to more accurately reimburse these hospitals for Medicare's portion of their indirect teaching costs.

One of the problems of reducing the additional payments for teaching costs is the adverse effect it could have on certain hospitals, mainly large inner city hospitals that have high levels of charity care. The charity care problem will continue as long as a portion of our population lacks resources to pay for hospital care. We believe that, in the absence of universal health insurance coverage, concerns about charity care costs should be addressed through a direct and targeted approach, not through PPS's indirect teaching adjustment. These two concerns, Medicare overpayments and charity care problems, should be addressed in concert.

Lastly, implementing the recently adopted resource-based physician payment system provides opportunities to bring the most rapidly growing segment of Medicare costs under control. Between 1975 and 1990 Medicare benefit payments for physician services increased more than ninefold, from about $3 billion to $29 billion.

We believe that the key to control is effective implementation of the volume growth goals that in effect place an overall limit on expenditures for physician services. Past efforts to control physician payments by limiting the fees paid have been largely unsuccessful because volume increases have offset the savings from constraining fees. Volume performance standards are the new reform's method to overcome this shortcoming. The Congress sought to provide a way to remove excess volume growth from Medicare, and we believe it chose a method with a high potential for success. In my earlier testimony before the full committee, I cited spending targets for major health care sectors as one of the methods used by other countries that have been most successful at cost containment. Consequently, we believe the implementation of the Medicare physician reforms is important not only to control Medicare costs but as a possible model for reforming physician payments overall.

BUDGET CUTS UNDERMINE ACTIVITIES TO PREVENT FRAUD, WASTE, AND ABUSE

Along with the changes in Medicare payments to control costs, program administration must be improved to assure that Medicare pays appropriately for services that beneficiaries receive. We have identified Medicare as a program that may be vulnerable to large losses to the taxpayer through mismanagement, waste, and abuse.

In a series of ongoing reviews, we are finding that program dollars are not being protected adequately. We believe that part of this mismanagement may be attributable to budget cutbacks that have affected program administration. In short, spending too little on administration translates into spending too much on the program. The effect is to forgo hundreds of millions of dollars in savings that could otherwise be attained.

Many of Medicare's administrative activities are carried out by contractors. The Health Care Financing Administration (HCFA) contracts with insurance companies to process and pay Medicare claims as well as perform a broad range of safeguard activities. Generally speaking, contractors assure that provider payments are limited to claims for covered, medically necessary services as determined by Medicare rules. The contractors are also the main channel of communication between beneficiaries and providers for matters relating to claims and coverage issues.

CUTBACKS IN SAFEGUARD ACTIVITIES RESULT IN LARGE PROGRAM LOSSES

Though Medicare's payment safeguard activities are cost-effective—returning nearly $14 for every dollar spent—contractor budgets to perform these functions have been cut each year since 1989. The administration requested $333 million for fiscal year 1992 for program safeguard activities, less than the amount spent in 1989, while projecting a 40-percent increase in the number of claims contractors will process. In 1990, HCFA estimated total savings foregone as a result of the reduction in Medicare safeguard activities to be nearly $500 million.

Even now, funding reductions have caused contractors to cut back on medical and utilization reviews that are essential in detecting and preventing erroneous payments. Contractors also attribute inadequate funding as the reason for not pursuing hundreds of millions of dollars owed to Medicare by private insurers and for fewer audits of the billions of dollars of costs claimed by institutional providers.

Failure to recover money from private insurers who cover Medicare beneficiaries is one of the most costly and pervasive problems we found in each of our contractor reviews. For example, one contractor had over a 3,000-case backlog where Medicare mistakenly paid about $8.8 million for services to beneficiaries who may have had private insurance. Although the contractor had identified private insurers after paying the beneficiaries' claims, it did little to recover the payments because of staffing constraints. Not coincidentally, the contractor's budget for this activity was significantly reduced in fiscal year 1990 and was not fully restored in 1991.

The irony of this situation is that in 1989 the Congress significantly strengthened HCFA's ability to identify beneficiaries having other insurance by authorizing such actions as Internal Revenue Service (IRS) data matches with Medicare records. The Congress anticipated additional Medicare savings of $1.6 billion over the next 3 fiscal years. Although tools such as the IRS data match have enhanced HCFA's potential to identify cases of mistaken Medicare payments, the anticipated program savings may never be realized if contractors are not given the necessary resources to recover the mistaken payments.

Another aspect of recovering payments involves collecting Medicare overpayments, or "credit balances," from hospitals. These credit balances, which represent monies due Medicare, often occur when both Medicare and another insurer pay for

the same services. Here too we found significant problems with contractors' ability to identify and collect overpayments.

To illustrate the problem, we identified $545,000 in credit balances owed Medicare by two local hospitals. Although these amounts had been outstanding for an average of 15 months, the contractor did little to recover the money. In fact, even when other hospitals we reviewed notified their respective contractors of the credit balances, collection action was seldom initiated. Apparently, the contractors had placed little priority on this area because of resources constraints.

PROPOSALS TO TRIM BENEFICIARY AND PROVIDER SERVICES CAN BE COSTLY

Proposed cutbacks in beneficiary and provider services are another area of contractor budgets that concerns us. Medicare beneficiaries are HCFA's first line of defense against provider fraud and abuse. Medicare contractors estimate that beneficiaries make about 90 percent of the fraud and abuse complaints referred for investigation. However, HCFA's fiscal year 1992 budget request reduces by nearly 60 percent the funding for contractor staff who respond to beneficiary inquiries. Such a significant reduction in the number of operators answering beneficiary telephone calls could result in contractors' losing over 900,000 fraud and abuse complaints a year.

HCFA's funding for contractor hearings and appeals activities is another area of beneficiary and provider services targeted for a 60-percent funding reduction. When beneficiaries or providers question a contractor's payment decisions, they are entitled by law to request that the contractor reconsider its initial payment decision. The resulting hearings and appeals activities help assure that beneficiaries and providers are not inappropriately denied payment.

Yet HCFA estimates that if its proposed cutbacks are authorized, nearly 70 percent of the hearings and reconsiderations expected in 1992 will be delayed. This means that 7 million cases, most of which involve Medicare beneficiaries, could encounter delays of 250 or more days before contractors consider their cases. Encouraging contractors to be aggressive in identifying and denying questionable claims, while limiting their ability to provide beneficiaries and providers their rights to question contractor actions, is a formula for serious problems.

CONTRACTOR BUDGETS SHOULD BE INCREASED

We believe that there is room for improvement in the efficiency and effectiveness of Medicare contractor operations. Over the years we have reviewed and addressed shortcomings in contractors' payment safeguard activities. We will also be issuing a series of reports on this issue starting later this year. HCFA likewise has concerns about the existing administrative structure and has undertaken a Medicare Contractor Reform Initiative to address these issues.

At least until other reforms are effectively implemented, funding cutbacks in such key areas as program safeguards are likely to cost much more than they save. Consequently, we believe that the more immediate solution to the problem lies in adequate funding of these important contractor functions.

The Budget Enforcement Act of 1990, however, imposed constraints on federal spending. This law provides, in general, that federal discretionary spending, which includes Medicare administrative expenditures, be subject to spending limits. The savings achieved are classified as mandatory, and so would not count as offsets to the increased spending for safeguard activities. This spending would, therefore, require cuts elsewhere in discretionary spending to remain within the established limits.

In recognition of a similar situation, the Budget Enforcement Act provided for discretionary spending increases for IRS compliance funding outside of the domestic discretionary funding caps. This permitted additional funding for IRS enforcement activities, without necessitating spending cuts elsewhere.

Because of the strong potential for a net reduction in federal spending, we recommend that the Congress establish a similar scorekeeping procedure so that increased expenditures to fund Medicare administrative costs for enforcement do not require offsetting reduction in domestic discretionary programs.

CONCLUSIONS

Medicare payment reforms can directly reduce program expenditures. The proposals set out above represent ways to enhance the effect of the Medicare reforms already enacted and identify opportunities for further reform.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or members of the Subcommittee may have.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. I don't have any questions.

Chairman STARK. Mr. Levin.

Mr. LEVIN. I have not had a chance to read the full report. I was listening to the summary with interest. I just want to mention something that you know that we constantly face, your suggestion in terms of the indirect medical education that we should address it through a direct and targeted approach, not through PPS indirect teaching adjustment.

I don't think it is within your domain but if you have any suggestions as to how we can do that, we would welcome them. It is a constant enigma for us. No one has suggested to us a guaranteed way to do that. So the proposals to reduce IME in essence become proposals to reduce payments to hospitals, many of which are under the most severe pressures. I know that it is not exactly your function to test the practicality of your suggestions but I just want to mention that as a cogent as this one is, so far it has proven impractical.

Mr. BOWSHER. Well, you are right in the fact that it is not easy, but we do feel that the funding uncompensated care partially through the Medicare indirect teaching adjustment puts a burden on Medicare costs that probably cannot be attributed to that. We have raised the issue as to whether a more direct method might not be appropriate and maybe should be given some consideration.

Mr. LEVIN. Thank you.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

You indicated in your testimony that we could save a significant amount of money in clinical lab reimbursement. Are you suggesting that we consider across-the-board cuts? Could you go into a little more detail as to some of the recommendations that you would make in order to try to deal with the problems that you brought out in your report?

Mr. BOWSHER. Yes. I think the situation is that you have different changes schedules for the different types of customers. It would seem to me that what maybe the Government has got to do is just to insist that the pricing through Medicare and to the Government programs not subsidize prices given to other customers. Laboratories are pricing to what they feel maximizes their profit situation and as our study indicates, what it results in is that Medicare payment rates result in a higher profit rate than those paid by doctors and hospitals.

Mr. CARDIN. Is this a situation that is across the board in lab services and if you were to look at some uniform reductions, would we be in danger of seeing some cost shifting perhaps to the private reimbursement plans?

Mr. BOWSHER. In all these situations we talked about, as was the case the last time I testified here on the overall health care costs, involves a lot of shifting among payers, that is right.

In other words, when we make recommendations that reduce the cost of Medicare, lots of times people then figure out how to move it into another area and, of course, vice versa. So a lot of it is like

that. There is no question in this case, Medicare is picking up a disproportionate share of the operating profits.

Mr. CARDIN. Would you estimate that to be about $150 million a year?

Mr. BOWSHER. Yes, sir, that is the amount we see.

Mr. CARDIN. Let me ask one additional question, about the teaching costs. I wonder if you have any specific recommendations on how to deal with teaching hospitals versus charity hospitals? I am very concerned that if we implement some of your suggestions with regard to teaching costs without the other side of that dealing with the charity care issues, that we will create some problems.

Mr. BOWSHER. Sure. That is why we have the statement in the report about our concern about charity care costs because I think you could easily have a situation where you reduce Medicare indirect medical payments without providing an alternative for funding charity care. If you don't do anything else you could put some of the major teaching hospitals in real deep trouble. It gets back to the issue we stated the other day about universal coverage. If we can go to some plan where we bring the people in and get everybody covered by the health care system in this country it seems to me then we would have some kind of a plan that would be reimbursing our inner-city hospitals and our teaching hospitals for those cases now classified as charity care.

But we have not done specific work about funding charity care while keeping the system as it is. It is something that maybe we should give some attention to.

Mr. CARDIN. Either universal coverage or an all-payer system would cover your concerns.

Mr. BOWSHER. Yes.

Mr. CARDIN. Thank you.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. Thank you, Mr. Chairman.

Let me delve into this clearly unbiased report that we are getting here. You commented about adequate funding for safeguard activities. What is it that Medicare is paying for now?

How did you find out about it? What can you tell us from your study? How are we being ripped off and who is doing it?

Ms. SHIKLES. The payment safeguard activity that we are talking about tends to fall into three categories: medical review activities to detect whether payments are being made erroneously, audits of cost reports, and the Medicare secondary payer category of activity, that is whether private insurance should have paid rather than Medicare.

So they fall in those three categories. That is what the administration proposes spending about $330 million for. We are doing a whole series of reports on those activities. Medicare gets a return of about $14 in savings for every $1 spent on those activities.

Mr. CHANDLER. So much is said about administration and the private sector and how inordinately costly it is. Here we have a public program and you are suggesting we are not spending enough on administration. It is kind of an interesting concept in light of the statement you just made.

Mr. BOWSHER. But it is the dilemma that you have. As long as you have our current system you have to have people checking up

on the administration, doing the audits and things like that. We were talking earlier back in our office about how there is hardly an institution that we go in that we don't see money owed to Medicare, which is sitting out there and not getting paid. So the current system forces that kind of administration and oversight. You have to do it well or you start to lose money.

Mr. CHANDLER. I assume an all-payer system would solve this problem, and we would never hear of this issue again?

Mr. BOWSHER. I would not say you would never hear this issue again, Mr. Congressman, but when we look at the system in other countries, they do have a lot less administrative costs simply because of the simplicity of the payment system.

Mr. CHANDLER. Thank you, Mr. Chairman.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. I pass, Mr. Chairman.

Chairman STARK. Mr. Russo.

Mr. RUSSO. Mr. Bowsher, in your testimony you stated the volume performance standards will effectively control physician expenditures. I agree with you that volume standards work when applied to the entire population.

I question their effect on physician behavior when they only apply to the 33 million beneficiaries on Medicare.

Would you comment?

Mr. BOWSHER. I think you have a point there. In other words, you don't have the same effect as if they applied to everybody but we would hope that they would have a beneficial effect when we apply it to this group of patients.

Mr. RUSSO. I wanted to compliment you on the GAO study which you did for the Government Operations Committee on single-payer. A single payer system with comprehensive benefits, would eliminate the administrative nightmare we face today under our multipayer system. As I recall, your study states that we would save $67 billion if we implemented the Canadian system here. It would cost $18 billion to give universal coverage and $46 billion to eliminate copayments and deductibles, so we end up netting $3 billion.

Am I stating it correctly?

Mr. BOWSHER. Yes, those were the numbers we had in that report.

Mr. RUSSO. In the study you took administrative costs under a single-payer system into consideration, right?

Mr. BOWSHER. That is right.

Mr. RUSSO. Thank you.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you.

Thank you, Mr. Bowsher. Just to pick up on the last line of questioning, it seems to me we have probably 1,500 health insurers in the country and probably as many pharmaceutical companies in the country.

Do you think these people are just going to go away as a result of going to a Government-oriented single-payer system?

Mr. BOWSHER. First, let me make clear to everyone that we are not endorsing a single-payer system and we are not saying you have to bring the Canadian system down here. What we are saying

is that when you study their system they did achieve those kinds of savings as best we could tell.

If you projected those types of savings into our system, that is the amount we thought you could get. What you could end up with in this country, as I pointed out to the Government Operations Committee, is a payment system where you would have more than one payer processing claims. That is what the Canadians have. Each of the Provinces really administers the program. The Canadian Federal Government makes a payment to the Provinces and then there is a provider payment mechanism in the Province. I would think that in some type of design of an American system, if we were to try to streamline the administrative costs and to streamline the payment systems, we would end up more like the German system with multiple payers, some of which might be in the private sector.

But I think you would get substantial savings in the number of people in the hospitals and doctors' offices that have to deal with all these different plans and forms, and also I think with some of the insurance companies.

Mr. McGrath. How feasible do you think it might be to take a system which is, as you point out, administered by 16 Provinces for 25 million people and overlay that on to a situation where there are 50 States along with the Federal Government administering a program for 250 million.

Do you think you could just expand it out?

Mr. Bowsher. No, we were not saying we thought you could in that report at all. We were saying if you look at the Canadian system and see what they did in 1971 versus how we have gone, there are certain real differences in the payment area and as we look at some of the other countries, which we will be reporting on here sometime in the future, you see five or six major payers but they all pay off a uniform fee schedule.

For example, I was recently in Japan and they have an insurance society that handles the major companies in Japan. Then they have another program for the small merchants and the people who don't have a job, which is not too many people right now in Japan. Then they have a program which is run by the national government for the elderly, and things like that.

They melded that kind of a payment system. They have features of the Canadian system as far as a single payment rate. In other words, everybody who goes to get a cataract operation is paying the same whether they are in the Toyota plan or the elderly plan and they have fewer people making the payments.

I think the American system, if it were to be redesigned has to be designed as you mentioned. We have a larger country, 50 States. We have States like California which have gone into HMO's successfully. That would have to be built in. In other words, there is a greater variety and much more flexibility would have to be built into any design of our plan.

Mr. McGrath. Let me get to the subject of the hearing. Perhaps I will take this up with Mr. Kusserow. An extensive study was done in the Bronx regarding the TENS units by a friend of mine in the New York State Legislature. A distributor of these apparatus would come in with a doctor, and they would ask people whether

or not they hurt anywhere. Obviously, they would say yes. The doctor would look at them and then write out a prescription and at the same time have the senior citizen sign a claim form.

The TENS unit would then be delivered to them within minutes. How can we avoid this kind of scheme?

Mr. BOWSHER. You mean overutilization?

Mr. MCGRATH. It is not only overutilization, it is a complete ripoff. I am not even discussing whether or not the device itself has any merit.

Perhaps it does. But the fact is simply that the system should be able to pick up this kind of abuse where you go to a room full of 300 senior citizens and you get rid of 250 TENS units at the same time. There has to be someone "watching the store" on this.

Mr. BOWSHER. Your last statement is exactly right, you have to have enough people watching the store and going out there and looking for these kinds of situations. You have to pick them up. I think Mr. Kusserow, when he comes to the witness table, can talk about his hot-line systems and all that. You would hope somebody would spot those kinds of things and report them and then you have to have enough people to go out and take a look at them.

Mr. MCGRATH. One of your statements concerned increasing Medicare contractor budgets. I assume you are talking about intermediaries. Isn't there some way that the local intermediary can look at the claim, 250 claims coming from the same area, and decide that something is wrong here?

Mr. BOWSHER. Yes, I would think so.

Mr. MCGRATH. Me, too.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

As to your last point in your exchange with my colleague from New York, isn't this why HCFA is recommending that PROs look at patterns of practice to be able to pick up those things?

Mr. BOWSHER. I think that is right.

Mrs. JOHNSON. I thought your statements and your testimony about technology and the way we reward technology were very significant.

You refer to the fact that you are developing a method that might be considered to make adjustments. The fact that we set payment levels when a technology is new and then don't adjust them is ridiculous. If an American factory based their costs on the initial cost of the first few items produced, they would not survive out there in the real world.

Mr. BOWSHER. That is right, it is the same principle.

Mrs. JOHNSON. That has been a real difficulty. How far along are you in developing some way of rationally dealing with this, and who else is working on this problem?

Mr. BOWSHER. We would hope to have our report to you sometime this fall.

Mrs. JOHNSON. Who else in the public and private sector is working on this?

Mr. BOWSHER. Janet tells me that she thinks that HCFA has some studies going on. Our team is working with whomever is working on it. We will get that information for you, Mrs. Johnson.

Mrs. JOHNSON. Much of your work in terms of lab costs seems to have been done with large labs. Just as in big business, large manufacturers differ considerably from the kinds of small manufacturers in my district that make large manufacturers possible in America. I would not want a health care system that had only a few large labs.

What makes you think the small labs are behaving the way the large labs are and that they are experiencing the same profit level, at in a sense a lower level of production?

Mr. DOWDAL. We looked at the smaller labs and saw their profit rate was similar if they had the range of customers. The ones that were different were the ones that only dealt with Medicare patients.

Mrs. JOHNSON. Are you are saying if they only had Medicare patients they did not have the same profit margin, correct?

Mr. DOWDAL. Their profit margin was somewhat lower if the only thing they dealt with was Medicare.

Mrs. JOHNSON. How much lower? Are you talking about a small lab that is primarily Medicare dependent?

Mr. DOWDAL. The overall profit rates were about 8 percent, if I recall, lower for the smaller ones.

Mrs. JOHNSON. Was their profit margin 3 percent or 8 percent?

Mr. DOWDAL. I would have to look that up. What we are saying is that——

Mrs. JOHNSON. There is a big difference between a profit margin of 3 or 8 percent. Are you saying 8 percent lower or 8 percent?

Mr. DOWDAL. What we based our work on was the principle in the Medicare Act which for a number of services says we will pay rates based on efficient and economic provision of services. We used the large labs as an example of efficiency and economical operation.

We then looked at smaller labs to see if they were comparable. Basically, for labs that were operating as most labs do, they were comparable. There was not a great deal of difference between the large and small labs.

On average it was about 5 percent. So a rough indication of the efficiency factor would be about 5 percent.

Mrs. JOHNSON. But there was a difference in small labs that were Medicare dependent?

Mr. DOWDAL. Right. Those were the labs, if the rates are reduced, those are the labs that would have to take some kind of action to get more efficient or else they could have financial problems.

Mrs. JOHNSON. You cannot necessarily take actions to increase volume in order to reduce costs per test in a small lab. Yet if you structure payments so you eliminate small labs, you do harm to access and to timeliness of service which can have very profound health impacts. So I ask you, did you look at how they could reduce costs other than by increasing volume?

Mr. DOWDAL. As always the companies compete. We did not specifically analyze the company where we were to see whether they had inefficiencies or not.

Mrs. JOHNSON. I would like to ask you to look at some of the small labs from that point of view. I think that is a relative point of view. A small lab with two people, with smaller space and no

other option in terms of rental of space, and with a certain quality of equipment to produce a certain quality of test may not have a way to cut costs.

We need to know this. You cannot say the big guys can do it for this and you little guys ought to be able to do it even though you produce much less. I think you have a responsibility to us to come back with a more in-depth analysis than you are suggesting.

Mr. BOWSHER. We will be pleased to do that.

Mrs. JOHNSON. Thank you.

Would you like me to cease questioning, Mr. Chairman?

Chairman STARK. We will come around again for a second round.

Mr. DONNELLY.

Mr. DONNELLY. Thank you, Mr. Chairman.

I note with interest your recommendation on reimbursement for indirect medical education. Do you have any recommendations on, or did you look at, direct reimbursement?

Mr. BOWSHER. No; we have not looked at direct medical education payments by Medicare.

Mr. DONNELLY. Why not? That is about half the cost of indirect.

Mr. BOWSHER. It was just not part of this study here.

Mr. DONNELLY. Well it is projected we are going to spend about $2.7 billion in the next fiscal year on indirect reimbursement and about $1.3 billion on direct. I think you have to look at the whole picture. It is not that I am objecting or taking issue with your recommendation but I wish you had thrown that into the mix.

Who in your opinion are the prime beneficiaries of these subsidies? I mean there is a reason that the Medicare system takes money from the trust fund. When money is taken from the trust fund it is basically taken from the beneficiaries. There is a reason we do that, to reimburse these hospitals to train physicians. In your opinion who would be the beneficiary of this $4 billion subsidy? Is it patients, the hospitals, or the physician?

Mr. BOWSHER. A lot of it is going to the institutions, the hospitals. Of course, the teaching hospitals I think are using the money from the Medicare Program to handle some of the charity patients that they have to handle, especially in the inner city and things like that.

So the hospitals are the main beneficiaries, I guess, of the subsidy coming out of the trust fund.

Mr. DONNELLY. Except the rationale behind the subsidy is that we offset hospitals cost to train physicians?

Mr. BOWSHER. That is right.

Mr. DONNELLY. It would be my contention that the ultimate beneficiary would be the physicians who are being trained. We are subsidizing the continuation of their education.

Mr. BOWSHER. And the patients they are working on who they might not be reimbursed for, because those people do not have coverage.

Mr. DONNELLY. Those patients could go to a nonteaching hospital. The system was not set up to take care of either the indigent or noninsured when the subsidy was created.

It was not intended for that but geographical distribution of where these facilities are may have created that. But the initial intention was to subsidize the training costs for physicians.

Wouldn't you conclude that the ultimate beneficiary is not the patients, but more the physicians? Because without the training he or she becomes ineligible to go out and earn a very lucrative living. Would you agree or disagree with my analysis?

Mr. BOWSHER. I think there is something to your analysis. I really do.

Mr. DONNELLY. This $4 billion subsidy that the elderly are paying to train physicians who then become some of the most highly paid people in the United States.

Mr. BOWSHER. Yes.

Mr. DONNELLY. What is the reimbursement to the taxpayers or to the beneficiaries who pay this subsidy?

Mr. BOWSHER. What is the reimbursement?

Mr. DONNELLY. What do they get out of it? What do they get out of it, the taxpayers?

Mr. BOWSHER. You would hope you would be getting better trained physicians to serve the elderly and the public.

Mr. DONNELLY. What do the physicians get out of it?

Mr. BOWSHER. They get the training.

Mr. DONNELLY. A $4 billion subsidy to train physicians in this country?

Mr. BOWSHER. Yes.

Mr. DONNELLY. What do the taxpayers get in return for that $4 billion subsidy? Zero is the answer. The physicians don't pay back. The average cost of subsidizing the training of physicians runs from $40,000 a year to $150,000 per year depending on the hospital.

So the system subsidizes the training of these physicians who then become some of the most highly paid people in this country.

Mr. BOWSHER. Are you saying the taxes these physicians pay is the pay back in the future to the Government?

Mr. DONNELLY. If we had a progressive tax rate maybe that would come back.

Chairman STARK. The Comptroller General has generated a lot of interest so we will give everybody a second chance.

Mr. Coyne, did you choose to inquire?

Mr. COYNE. Not at this time.

Chairman STARK. Mr. Levin, we are going around a second time.

Mr. LEVIN. I have a quick question if I might. On page 37 where you are talking about the oversight of HMO's and essentially the only remedy is contract termination, you say consequently you believe that Congress should consider broadening HCFA's sanctioning authority, for example, by authorizing civil and monetary penalties when HMOs do not comply with PRO review requirements. Let me just ask you whether you think that if we granted this expanded authority there is the will within HCFA to carry it out?

Mr. BOWSHER. Janet works mostly with HCFA so I will turn it to her.

Ms. SHIKLES. We have serious concerns about how they have run the program. Very recently they have reorganized that office. We have not taken a specific look at it but the reorganization suggests that they may be more vigorous in their oversight of the HMO program. We would hope that if they were given that authority, they would.

Mr. LEVIN. Has the only problem been, you think the existence of only an extreme penalty or have there been other problems within HCFA preventing the kind of surveillance and oversight necessary.

Ms. SHIKLES. One of the problems is that HCFA only had a very extreme penalty and they were reluctant to use it. We have already testified and reported that they have not used the PRO contract very vigorously to monitor quality assurance activities in the HMO program. They have not used the data.

When they found problems in the HMOs they did not take action. We believe our report and recommendations led to the reorganization in HCFA that will separate the advocacy side from the oversight.

We are hoping that will improve the oversight.

Mr. LEVIN. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. No, thank you.

Chairman STARK. Mrs. Johnson, do you have a further inquiry?

Mrs. JOHNSON. I have a specific question and a general one.

In the lab area, did you take into account the costs of the new CLIA regulations either in the course of analysis or as a secondary aspect?

Mr. DOWDAL. The regulations have not been finalized yet, so we have not.

Mrs. JOHNSON. Could you be prepared to do that in short order when they are?

Mr. DOWDAL. The regulations have been proposed and HCFA has received comments and is working on finalizing them.

Mrs. JOHNSON. The more recent batch of CLIA 1988 regulations?

Mr. DOWDAL. Yes.

Mrs. JOHNSON. We certainly would need that information. Would you agree that they will make a significant difference to the cost of testing?

Mr. BOWSHER. It probably would but let us take a look and get back to you.

Mrs. JOHNSON. They would increase the cost of testing?

Mr. BOWSHER. I think so.

Mrs. JOHNSON. If the only problems in testing that were discovered were problems in labs that had not been certified, it might be cheaper to require all labs to be certified rather than put these regulations in place. But we should be able to see precisely what new costs are being proposed and perhaps then take more action.

Regarding the American and Canadian systems would you agree that the fundamental difference between their system and ours is that we have fewer general practitioners and many more specialists?

Mr. BOWSHER. The fundamental difference is the payment system.

Mrs. JOHNSON. I would differ on that. I would say that the structure of the industry is different. Do you agree that the structure is different?

Mr. BOWSHER. There is no question.

Mrs. JOHNSON. I think your analysis of administrative costs and this report is a perfect example. You are telling us we have to beef

up administrative costs, and increase the money we put into safeguarding.

Mr. BOWSHER. As long as you have the present system.

Mrs. JOHNSON. We must, in order to control volume. In a system which has few generalists and lots of specialists, volume will continue to be the issue. As long as the generalists are liable under our system of malpractice, they cannot not refer to the specialists because they would be liable.

They cannot decide not to do the tests because they would be liable. In your report you say there is a big problem with unnecessary tests or extensive diagnostic tests.

Mr. BOWSHER. Yes. We also pointed out a major difference in medical malpractice costs.

Mrs. JOHNSON. A 10 times difference between the cost in Canada and here is not the real issue. That is the problem. This issue of volume of diagnostic tests is very directly related to the different liability system in each nation. So if you are going to reduce administrative costs in our system in the way that Canada has reduced administrative costs, you must also change the requirements for diagnostics and other things.

One of the things that is necessary is changing the legal environment in which the decisions are made. That is not, however, the most important issue that I want to address here. What I want to say is that I do not understand how you can propose that we go to Canada's system of administrative costs when clearly to control volume you are recommending we increase administrative investment in our system. Our national experience with the difference between first-dollar Cadillac coverage and the usage under that plan versus usage under a structured plan that requires copayments is very clear in terms of costs.

You can either constrain volume through copayments, or you can constrain payment by volume, which is where you determine the necessity of a service.

In the Canadian system, they constrain volume through fees. If you want us to go to the administrative costs of the Canadian system, you should advocate a restructuring of fees which may then constrain volume as it does in Canada.

Mr. BOWSHER. Let me say we addressed many of these issues. I did not recommend that we go to the Canadian system. What we said was that we thought there were features in the Canadian system that should be considered. One was the Canadian payment system. They have achieved some of their lower costs because of a more simple payment system. We did not recommend the Canadian system, that it be brought down here intact.

Some of the issues that you are raising, some of those issues are very valid.

Mrs. JOHNSON. In reading your report, and I intend to pursue this with you at some greater length later. While you may not have recommended that we adopt the Canadian system, the dollar figures that you derive as a cost savings assume that we could administer our system in the way they can. But your testimony here today clearly demonstrates that we cannot administer our system the way they administer their system. We have to have the ability to look at an appropriateness of care, and constrain volume and

therefore cost by the measure of appropriateness. All of our investment in guidelines and outcomes research, all the changes going on in HCFA, and the specific goal of rationalizing is laying a rational scientific foundation for us to constrain volume.

Now, if you are going to do that, you are going to have to have the look-see capability to assure that those practice guidelines are implemented. In a single-payer system or the kind of payer system that Canada has, without that oversight capability you cannot constrain volume and therefore cannot constrain costs in America.

If you differ from that, I hope that you will make very clear right now how you think we can constrain volume without administrative capability. This is a fundamental issue. The only way you can get to the dollar figures in your report is to go to the kind of very simple administrative mechanism that Canada has, and that mechanism involves nothing other than payment.

Payment does not end up being the primary issue in cost, although it is an issue. Certainly the chairman in his testimony yesterday indicated that we are overpaying for a lot of fees and so does your report, but that is not the big money. The big money is volume, and we found that because when we cut the cost of hospital care, outpatient care went up.

We punched the balloon one place, but unless you change the liability restriction, cost are going to be up there. Your numbers in your proposal have clearly indicated that you are comparing what would happen if we went to that kind of payer system. But that kind of payer system has no quality or volume appropriateness oversight capability. I don't think America can adopt that and control costs.

Do you think we can adopt that system and control costs?

Mr. BOWSHER. Well, the thing that impressed us is that not only in Canada, but other countries seem to have controlled cost with that type of system more than we have been able to control.

Mrs. JOHNSON. I am absolutely not saying that we can't make some savings, but the dollar figures you suggest in your report that we could save are to me, misleading and unfounded.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

I don't intend to beat a dead horse, but I think it is important for the record to show and the General Accounting Office to understand that hospitals, teaching hospitals are not the only beneficiary of this indirect subsidy and the direct subsidy, that the ultimate beneficiary, in my opinion, are those that receive this training and then earn a very high salary, the physician itself, and that there is no payback from those people who profit off the subsidy to the system.

Mr. BOWSHER. I see what you are getting at.

Mr. DONNELLY. I don't ask you to comment in one way or another. Maybe it is good public policy. Maybe we ought to spend $4 billion a year training physicians. I mean, maybe we should do that. I know of no other profession, accountants, lawyers, et cetera, that receives that sort of subsidy.

There has been a subsidy since 1965, and it probably made a lot of sense in 1965 to prop up the health care delivery system. I ques-

tion whether it makes that much sense in 1990 or the necessity of having that large subsidy in 1990.

Most especially, I question the fact that we, the taxpayer, or the beneficiary do not receive much of a payback on that.

Mr. BOWSHER. I think we are in more agreement than maybe I realized a few minutes ago. That is the issue that we are——

Mr. DONNELLY. Had you attended more committee hearings, you would realize I asked this question of everybody.

Mr. BOWSHER. The one caveat I wanted to have on our report was the inner-city hospitals and the uninsured clientele that they have to cope with sometimes.

Mr. DONNELLY. But I would agree that there is—that physicians receive some sort of benefit, no question about it.

Mr. BOWSHER. No question.

Mr. DONNELLY. I was very much interested in your statement on page 5 regarding charity care and your recommendation that we should address this issue through a directed or targeted approach.

Could you amplify on that? What do you mean?

Mr. BOWSHER. What we basically mean there is, if we have to pay for uncompensated care then maybe we should have some kind of a program to handle that. We don't have a program designed like that, but that is the issue we are trying to raise here.

In other words, instead of subsidizing it through Medicare, maybe you should have a program to take care of uncompensated care or some kind of a program to handle what obviously is a big cost item, and that is the people that are outside the system that have to be taken care of.

Mr. DONNELLY. Do you think the overpayment in the indirect subsidy is being used by most especially the inner-city teaching hospitals to subsidize their charity care?

Mr. BOWSHER. Yes.

Mr. DONNELLY. Almost all——

Mr. BOWSHER. Of course, it is also going to hospitals that don't have a high percentage of charity care, too.

Mr. DONNELLY. Exactly. Almost all, if not all teaching hospitals are nonprofit corporations exempt from any State, local or Federal taxation. They are charitable corporations. Charitable corporations, by definition, because of their nontaxable status, have a responsibility to provide some sort of public good and/or charity.

The full Committee on Ways and Means is going to have a hearing next month on legislation that I filed trying to really define what is charity care and if, in fact, these institutions have a responsibility to provide charity care, that it is not the responsibility of the Medicare system to subsidize charity care. It is a responsibility of a nonprofit organization who has no tax liability to provide it.

Would you like to comment on that.

Mr. BOWSHER. Why don't you take that.

Mr. SHIKLES. We issued a report last year where we identified that problem. There was a set of nonprofit hospitals that weren't providing that much charity care, and——

Mr. DONNELLY. There are nonprofit hospitals in this country that won't accept Medicaid patients.

Mr. SHIKLES. That is correct.

Mr. DONNELLY. Well, being a Medicaid patient by definition is being poor, so that by definition might make you somewhat of a potential charity. What is your position on hospitals that won't accept Medicaid patients, nonprofit entities that wouldn't accept Medicaid, which is a Federal program?

They will accept Medicare. They will take the subsidy, which you say we are way overcompensating. They will take the payment for Medicare action and every other subsidy.

Mr. BOWSHER. Obviously, we think they should take the Medicaid patients.

Mr. DONNELLY. So you think that nonprofit corporations should take them?

Mr. BOWSHER. Sure.

Mr. DONNELLY. It is nice to meet somebody who agrees with me. It is so rare. Well, thank you, Mr. Chairman. Again, I really appreciate you recommendations. Let me just say in conclusion that teaching hospitals are something this committee should look at very closely, most especially that we are overreimbursing in some instances, and we ought to separate the subsidies.

We really ought to separate the charity care responsibilities of institutions from a program that was designed to subsidize the training of physicians and nurses in this country. They are two separate issues, and your recommendations will be very well-received and welcome.

Thank you.

Chairman STARK. Thank you.

Mr. Bowsher, in your testimony you make a recommendation in terms of a change in the budget law or Budget Act. If I understand what you are suggesting, it is that in competing for enforcement funds, we are competing with direct spending which could improve the life of our constituents in one way or another. Therefore, we tend to not do as well in the arena of the Appropriations Committee. Futhermore, you cite that funding for IRS enforcement is outside of discretionary funding caps because it, in fact, returns more dollars than we spend.

There is a concern that this would be, as I have often said, like tugging on the string of a double-knit suit. I, for instance, have been concerned that we don't get scored for savings in child care in the out years. If we spend some money on preventative care, we know instinctively that that saves money down the line, but because of the way we account for things in the Federal Government, we are not allowed to take that into consideration.

If it gets spent, could you assure us that this could be drafted in such a way as to not start an endless chain of more people trying to get special exemptions from the Budget Act and reassure those who might be worried about that?

Mr. BOWSHER. I can't really assure you of that. In other words, I think that one of the dangers of adopting it for any program is other programs will come in and ask for exemptions. But I really do believe, and you have articulated it well, that lots of times we save money in one part of the budget and actually lose money in another.

I think the classic case in recent years is when we deregulated the S&Ls and then cut back on the supervision and the oversight,

and now we are paying billions and billions of dollars. So it seems to me that there are certain areas——

Chairman STARK. Let me ask this. Would you be prepared to rank this as one of these?

Mr. BOWSHER. I would be more willing to say one of them—in other words, we gave this quite a bit of thought before we included it in today's testimony.

Chairman STARK. I understand that, but I am thinking of going before the Budget Committee on the strength of your testimony, but I am worried to find there are 10 areas you might recommend this and I am only the seventh.

Mr. BOWSHER. Maybe what we should do is go back and look at some of the other areas and come back to you.

Chairman STARK. If you could say that this is one of the most productive, it would help us.

Mr. BOWSHER. See, as Janet is reminding me, one of the big things is the amount of dollar earnings involved. In other words, we recommended it some years back for the IRS because of the big dollars involved.

That is your revenue. You are trying to take in a trillion dollars a year through a revenue service. To cut the people that are running that system doesn't make a lot of sense.

So we look at Medicare as another big dollar program, but let us do some additional thinking on it.

Chairman STARK. Thank you. I have one other question, which I know all of my colleagues come across as well. This morning as I was looking through my mail, if you will permit me, I will read it quickly. The letter is addressed to Pete Stark. It says,

> As a social worker in the Bay area for over 15 years, I want to bring to your attention problems created by reductions in medicare OBRA 90, affecting seniors and their need for durable medical equipment in their homes.
>
> Case in point, client's hospital bed. Medicare is now paying 50 percent less to vendors for equipment. Vendors no longer are taking medicare assignments, which result in client not getting needed beds. This equipment allows seniors to stay in their home and avoid institutionalization.
>
> Very truly yours.

I suspect that this is not truly accurate, but without starting a full scale investigation of what is going on in the Berkeley area, it would be helpful to a lot of members as they try and decide what we are going to do about tightening up on regulations or loosening up because we will be inundated. Manufacturers are talking, for instance, about the fact that people aren't taking Medicare assignment for wheelchairs. They just can't make any money under it.

I suspect that some of that may be crying wolf but some of it may be true. Is there a procedure that does not jam up your department where somebody could give us a quick opinion as to whether this is within the ball park or completely erroneous?

Are you prepared to respond to this or would I be putting an unfair burden on your operation?

Mr. BOWSHER. We are looking at some of those things right now in our San Francisco office, so maybe we could take a look, use that as input and see if we could be helpful.

Chairman STARK. OK. I think what I am looking for is a yes or no answer. Then I will be able to decide whether or not, depending

how many letters I get like this, whether I want to go into the issue in detail.

One other question. Let me ask you about this hassle factor. I am constantly hearing from physicians about this issue. Now, I rather suspect in many of those cases it is because Medicare doesn't pay for the service. The doctor thinks that is wrong, and I am not competent to decide whether the doctor's assessment of whether or not it is a medically necessary service.

You did an extensive report in Canada; is that right?

Mr. BOWSHER. Yes.

Chairman STARK. Are you doing a report on other countries at this point?

Mr. BOWSHER. Yes, we are.

Chairman STARK. Can you recall just off the top of your head generally out of the entire Canadian system what the percentage of overhead and administration is? Mr. Russo is whispering in my ear, 11 percent or 11 cents on every dollar.

Mr. BOWSHER. We don't have it right off, but we can certainly supply it for the record.

[The following was subsequently received:]

GAO does not have data on the percentage of overhead and administration for the entire Canadian health system.

Chairman STARK. Do you know what it is in Germany?

Mr. BOWSHER. We have those numbers. I don't have them with me right now.

Chairman STARK. Would you guess it is close? You have been there.

Mr. BOWSHER. Yes. In other words, it is lower in both—in all of these systems that is what we are finding.

Chairman STARK. In the Blendon report, it suggested that the public may not trust the Government to administer these systems. Do you know of anybody in the country who administers a large medical payment system any better than HCFA?

Mr. BOWSHER. In fact, I think the HCFA administrative costs, when you look at a percentage, is down there pretty close to what these other countries have. It is really the other programs that have the higher costs.

Chairman STARK. So what you would suggest is that empirically our Government's record for administering the payment of medical claims is pretty efficient?

Mr. BOWSHER. Yes, I think that is a fair statement.

Chairman STARK. This has been inferred in other questions, but have you or your staff come across anything other than a single-payer or all-payer paying a single rate system that you would feel would be efficient in controlling overall costs in this or any other country?

Mr. BOWSHER. Well, what we are looking at is the variety of the systems in these other countries, and they all have different features, and I think when we get this next report out, it will be very helpful, then, for everybody to see what the variety is.

But they generally come back to those—to a principle there of single——

Chairman STARK. I just haven't heard of any other system other than a so-called free market which I don't think exists in the medical delivery system.

Mr. BOWSHER. Not in any large industrial country.

Chairman STARK. Thank you. Thank you and your staff. Are there other members who want to further inquire? Mr. Russo.

Mr. RUSSO. Mr. Bowsher, when you studied these costs for direct medical and indirect, as Brian Donnelly has stated, did you factor in the trainee's hours at work?

Mr. BOWSHER. No, I don't think we went to that detail.

Mr. RUSSO. You reimburse teaching hospitals for indirect expenses. Is it for services rendered by the trainee?

Mr. DOWDAL. It is an economic analysis of overall data comparing the kinds of patients treated by teaching hospitals versus hospitals that aren't and trying to discover in that process what the reasons for the difference in cost are.

The actual payment for the interns and residents comes under another part. That is not paid through the indirect. That is the direct medical education payment.

Mr. RUSSO. But under the direct, the intern's hours, that is how you——

Mr. DOWDAL. That would be in there, yes.

Mr. RUSSO. The reason I asked this is we have had a few bad instances in Illinois where residents have to work 36 straight hours, which exhausts them. God forbid that at the 34th hour there is a major auto accident that they have to handle. Have you looked into the efficacy of having residents work 36-hour shifts? They call them rotations.

Mr. BOWSHER. No, we have not done work on that.

Mr. RUSSO [presiding]. Do you think it is a good idea that people work 36 straight hours on call?

Mr. BOWSHER. No. In fact, I can remember when I was in graduate school at the University of Chicago, I had a part-time job over at the university hospital, and I had a lot of friends in the medical class and in the interns and that, and I used to think it was horrific hours.

It apparently hasn't changed much.

Mr. RUSSO. I think it is a huge mistake because I think some serious problems arise. Patients' lives are put at risk. What do you think of legislation that would say no hospital can be reimbursed under Medicare that has an intern program that makes them work more than 12 hours on any one rotation?

Mr. BOWSHER. I would have to give that some thought before I would comment on that.

Mr. RUSSO. Would you? Because I am very concerned about what is going on with these young people who are trying to be trained, and I think we need to address it, and maybe some comment from you on whether or not you think that is something we ought to be doing or not will start the ball rolling.

I think it is an absolute disgrace that these young people are training under these conditions, and all it does is give them the opportunity of making a major mistake some day.

It may affect somebody's life. I don't think the hospitals really want to do that. I don't quite understand the policy behind a 36-

hour rotation, so if you can help me understand that, then maybe I won't put the legislation in, but if not, I am certainly going to try to move on it.

Thank you. Thank you very much.

If there are no other questions, we want to thank our witnesses. Thank you very much.

Our next witness is the Honorable Richard Kusserow, Inspector General in the Department of Health and Human Services. He is accompanied by Larry Morey, Deputy Inspector General of Investigations.

Mr. Kusserow, welcome to the subcommittee. You may proceed to summarize your written statement. It will be made a part of the record.

STATEMENT OF RICHARD P. KUSSEROW, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LARRY MOREY, DEPUTY INSPECTOR GENERAL OF INVESTIGATION

Mr. KUSSEROW. I am Inspector General for the Department of Health and Human Services. That makes me the inspector general for both Medicare and Medicaid. I will, in fact, take up your offer to provide some highlights from my testimony.

Needless to say, it has been made clear from the testimony heard this morning that the escalation in the rate of health care costs to the taxpayers is continuing. It invariably rose at twice or thrice the overall inflation rate. Our health programs are the fastest growing segment of the Federal budget.

It is necessary to point out that health care now is the number one industry in the United States and has been for a number of years. This has had an effect not only on the budget in terms of adding to the red ink of the Federal Government, but also has, in a larger picture, impacted on our balance of trade as it relates to the health care component that goes into the manufactured products in the United States. So it is not surprising that health care costs continue to be a very great concern of both the administration and of Congress.

As we are the principal oversight party for health programs in the Department, I think I would also like to note that not only has the cost of Medicare been rising at a very, very great rate, but also that it is beginning to become very, very complex as we go along.

The complexity was added to by the prospective payment system that we brought about in 1984. Other factors adding to this complexity include requirements for nursing homes, passages of laws mandating regulation of laboratories, which was alluded to also under CLIA, the development of new resource-based reimbursement system for physicians, the whole relative value scales issue. These changes have increased enormously the complexity of this rising cost program. It is hard to believe that in the last 5 years that the growth of Medicare has been around $43 billion. This is extraordinary in terms of not only the commitment of the Federal Government to the elderly, but also it has really created an oversight problem of immense proportions.

During the same period the programs were advancing greatly, we have remained fairly static in our resources in trying to oversee the program. We now have a situation where each one of our employees in the Department is responsible for oversight of $382 million. This is unmatched by any other department. In HUD's inspector general's office, each FTE represents about $52 million, VA, $79 million. At the Defense Department, it is one FTE for every $213 million, but this doesn't count the DCAA which has roughly 68,000 auditors and probably another 4,000 criminal investigators outside or a total of maybe 20,000 people on oversight outside of the inspector general's office, but still within the Defense Department.

The point I would make, though, is not that we are not trying to rise to the occasion or not that we are not making some sufficient progress in this area. During the same period of time that Medicare was rising by almost two-thirds, I would point out that our sanctioning and prosecutions in the area of health care fraud and abuse kept pace and we prosecuted at that same rate, and today we have about 1,100 individuals and entities that we prosecuted administratively and criminally for engaging in fraud or abuse of practices against our programs and our beneficiaries.

I note with interest that the testimony from the Blue Cross-Blue Shield Association talks about the safeguard budgets and their commitment to trying to help protect and safeguard the Medicare program with their audit functions, detecting fraud, and referring to our office.

I would mention in passing that I have been a stalwart in testifying year after year in support of the safeguard component of the contractor budget because I do think it is a good, basic area and is a worthwhile investment.

At the same time, I would note that the quality of the return that we get from the contractors in this arena varies enormously, particularly as it relates to the area of referral of possible cases for investigation. Unfortunately, we only get about one out of five cases that we prosecute from the contractors. We think that they can do a much better job in that arena.

As was mentioned in the opening statement, we have issued in conjunction with this hearing a report that is really trying to deal with the crux of what I think this committee is trying to work with, and that is maintaining the solvency of the Medicare trust funds, and we have made that report available today and have released it to the public in that effort.

What we have tried to point out here, is that during our analysis of the Medicare programs, we have looked for where there were opportunities to tighten up the program, strengthen the program, and provide some estimates as to what the annual savings would be, always looking toward the fact that we want to maintain this very vital program and the promise that we have made to the elderly for quality health care.

If we were to somehow have all these recommendations implemented, I assure you it would strengthen the programs and would lengthen the period of solvency of these trust funds for many, many years beyond what is now projected, which is the year 2015.

I also mentioned in my testimony selected areas where we think that is worthy of Congress to examine the Medicare program.

The first point that I had made in my written statement was in the area of contractor reform. I think that this is overdue. We seem to be still fossilized in 1965, and have not taken full advantage of the rising technology that has occurred since then.

It seems to me that we have far too many contractor systems; we have far too many opportunities for people to have inconsistencies in the program. It is beyond me that in looking at 1990s technology we saw applied in Desert Storm that we could look in this country and realize that people who provide services in the Medicare program would have variances in how they are paid and where they are paid around the country. It seems to me that everybody in the United States should be paid exactly on the same basis at the same time for the same kind of services going to the same kind of beneficiaries in the same program. We think there should be a lot of improvement in the technology, that it should be a universal system with the same standards as to how people are paid and when they are paid and also the quality of services that should be expected for that payment.

We also looked at an area that was brought up by Mr. McGrath earlier about durable medical equipment and some of the lingering problems that we have in that area. There have been a number of efforts on the part of the administration and the Congress to deal with some of the more abusive practices in that area.

Unfortunately, we still see that there is a situation where, once again, the variances that exist in policies and the manners in which payments are made by carriers around the country permit certain unscrupulous suppliers to find the weak link in the overall chain and run all their bills through that one carrier and, therefore, maximize reimbursement.

We have made recommendations along that line for quite some time. We hope that further pressure in this area will bring about further changes that will eliminate this type of abuse, particularly, I would note—and I look with great pleasure on the fact that one of the other witnesses is also pointing out that they have submitted a proposal that a payment be made, based upon the locality of the beneficiary and not to permit somebody to go around the country looking for some weak link in the carrier chain to get their billings.

My testimony also focuses on Medicare secondary payer and some of the problems of reimbursement manipulation, but for the sake of time here, why don't I conclude my remarks and just leave whatever time remains for questions and answers.

[The prepared statement follows:]

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TESTIMONY OF RICHARD P. KUSSEROW, INSPECTOR GENERAL U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

GOOD MORNING, I AM RICHARD KUSSEROW, INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WITH ME IS LARRY MOREY, THE DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS. THANK YOU FOR THE OPPORTUNITY TO TESTIFY ON SEVERAL SIGNIFICANT ISSUES PERTAINING TO THE DEPARTMENT'S HEALTH CARE FINANCING PROGRAMS. MY TESTIMONY TODAY WILL FOCUS ON SPECIFIC AREAS OF THE MEDICARE PROGRAM THAT ARE SUBJECT TO FRAUD, WASTE, AND ABUSE, OR INEFFICIENCIES AND EFFECTIVENESS. I WILL ALSO PROPOSE OPTIONS FOR FURTHER REDUCING FRAUD AND ABUSE AND FOR IMPROVING THE FINANCIAL VIABILITY OF THE DEPARTMENT'S HEALTH PROGRAMS.

INTRODUCTION

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) IS THE FEDERAL GOVERNMENT'S PRINCIPAL AGENCY FOR PROMOTING THE HEALTH AND WELFARE OF AMERICANS AND PROVIDING ESSENTIAL HUMAN SERVICES TO PERSONS OF EVERY AGE GROUP. HHS TOUCHES EVERY ASPECT OF LIFE FOR EVERY AMERICAN CITIZEN, FROM CRADLE TO GRAVE. THAT MAKES IT ALL THE MORE IMPORTANT THAT PUBLIC CONFIDENCE IN OUR ABILITIES AND INTEGRITY REMAIN HIGH.

IN 1990, MEDICARE, ADMINISTERED BY THE HEALTH CARE FINANCING ADMINISTRATION (HCFA), PAID APPROXIMATELY $63 BILLION IN PART A BENEFITS AND APPROXIMATELY $45 BILLION IN PART B BENEFITS. THE FEDERAL GOVERNMENT USES TWO SEPARATE TRUST FUNDS TO ACCUMULATE RECEIPTS AND MAKE DISBURSEMENTS FOR THESE BENEFITS. THE HOSPITAL INSURANCE (PART A) TRUST FUND AND THE SUPPLEMENTARY MEDICAL INSURANCE (PART B) TRUST FUND ARE EXPERIENCING INCREASING FINANCIAL PRESSURES. MEDICARE PART A, IS FUNDED PRIMARILY BY PAYROLL TAXES ON EMPLOYERS AND EMPLOYEES, WHILE MEDICARE PART B IS FUNDED BY PARTICIPANTS (25 PERCENT) AND GENERAL REVENUES (75 PERCENT). THE MEDICAID PROGRAM IS A JOINT FEDERAL-STATE PROGRAM WHICH PROVIDES MEDICAL CARE FOR MORE THAN 25 MILLION LOW-INCOME PEOPLE (MORE THAN $50 BILLION FEDERAL SHARE).

DURING THE PAST DECADE, THERE HAS BEEN INCREASING CONCERN REGARDING THE COST AND FINANCING OF THE DEPARTMENT'S PROGRAMS. WHEN THE VARIOUS PROGRAMS WERE CREATED, NO ONE COULD HAVE PREDICTED THE RATE OF INCREASE IN THE COSTS OF THESE PROGRAMS AND THE DRAIN THEY WOULD PLACE ON OUR OVERALL BUDGET. DEMOGRAPHIC CHANGES, INCREASES IN LIFE EXPECTANCY, CHANGES IN TECHNOLOGY, RISING RESOURCE COSTS, AND OTHER CHANGES IN OUR SOCIETY HAVE CONTRIBUTED TO RAPID GROWTH IN PROGRAMMATIC EXPENDITURES. JUST A FEW STATISTICS ILLUSTRATE HOW THE HEALTH CARE AREA HAS CHANGED AS WELL AS SOME OMINOUS FUTURE TRENDS:

- NATIONAL HEALTH EXPENDITURES WERE $51 BILLION IN 1967, 6.3 PERCENT OF THE GROSS NATIONAL PRODUCT (GNP). BY 1990, EXPENDITURES REACHED $647 BILLION, 12.2 PERCENT OF GNP. NO OTHER COUNTRY IN THE WORLD EXPENDS SO MUCH OF THEIR GNP FOR HEALTH CARE. THE REST OF THE INDUSTRIALIZED WORLD EXPENDS ONLY BETWEEN 5.6 AND 9.6 PERCENT OF GNP ON HEALTH CARE WITH OUTCOMES THAT EQUAL OR SURPASS THE UNITED STATES. FOR EXAMPLE, THE UNITED STATES SPENDS 35 PERCENT MORE PER CAPITAL THAN CANADA, 91 PERCENT MORE THAN WEST GERMANY, 124 PERCENT MORE THAN JAPAN, AND 173 PERCENT MORE THAN THE UNITED KINGDOM.

- PUBLIC EXPENDITURES ON HEALTH AMOUNTED TO $19 BILLION IN 1967, 37 PERCENT OF TOTAL HEALTH EXPENDITURES. PUBLIC HEALTH EXPENDITURES REACHED $269 BILLION IN 1990, 42 PERCENT OF TOTAL HEALTH EXPENDITURES.

- NATIONAL HEALTH EXPENDITURES PER PERSON INCREASED FROM $247 IN 1967 TO $2,511 IN 1990.

- NATIONAL HEALTH EXPENDITURES ARE PROJECTED TO REACH $1,529 BILLION IN THE YEAR 2000, REPRESENTING 15 PERCENT OF THE GNP.

- WITHOUT FURTHER INTERVENTION, IT IS PREDICTED THAT THE HOSPITAL INSURANCE (PART A) TRUST FUND WILL BE EXHAUSTED IN 2006.

A NUMBER OF GOVERNMENT AGENCIES AND GOVERNMENT-APPOINTED GROUPS HAVE STUDIED AND MADE RECOMMENDATIONS TO IMPROVE THE MEDICARE PROGRAM. THEY INCLUDE THE ADVISORY COUNCIL ON SOCIAL SECURITY, THE MEDICARE BOARD OF TRUSTEES, THE CONGRESSIONAL BUDGET OFFICE, THE GENERAL ACCOUNTING OFFICE, AND HCFA.

THE CONCLUSION REACHED BY THESE GROUPS IS THAT SIGNIFICANT CORRECTIVE ACTION IS NECESSARY TO ENSURE THE FINANCIAL VIABILITY OF THE MEDICARE PROGRAM.

- IN MARCH 1991, THE HEALTH TECHNICAL PANEL TO THE 1991 ADVISORY COUNCIL ON SOCIAL SECURITY CONCLUDED THAT "...THE CURRENT STATUS OF THE MEDICARE PROGRAM IS PRECARIOUS, AND THAT THE STATUS QUO CANNOT BE MAINTAINED...POLICY MAKERS WILL HAVE TO MAKE A NUMBER OF DIFFICULT CHOICES ABOUT HOW TO ...CONTROL COSTS."

- THE MAY 17, 1991 REPORT BY THE BOARD OF TRUSTEES OF THE PART B FUND STATES THAT "...THE BOARD NOTES WITH CONCERN THE RAPID GROWTH IN THE COST OF THE PROGRAM.... THE BOARD RECOMMENDS THAT CONGRESS CONTINUE TO CURTAIL THE RAPID GROWTH IN THE COST OF THE...PROGRAM."

- THE MAY 17, 1991 REPORT BY THE BOARD OF TRUSTEES OF THE PART A FUNDS CONCLUDED THAT "...BECAUSE OF THE MAGNITUDE OF THE PROJECTED ACTUARIAL DEFICIT IN THE...PROGRAM AND THE HIGH PROBABILITY THAT THE...TRUST FUND WILL BE EXHAUSTED SHORTLY AFTER THE TURN OF THE CENTURY, THE BOARD BELIEVES THAT CORRECTIVE ACTION WILL BE NEEDED VERY SOON IN ORDER TO AVOID THE NEED FOR POTENTIALLY PRECIPITOUS CHANGES LATER."

WE ALSO NOTE THE AFFORDABILITY, ACCESS, AND EFFECTIVENESS OF HEALTH CARE DELIVERY HAS BECOME A PRIMARY CONCERN OF THE PRIVATE SECTOR. IT ALMOST APPEARS THAT PROPOSALS TO REFORM HEALTH CARE ARE ISSUED DAILY BY VARIOUS HEALTH INDUSTRY GROUPS, LABOR ORGANIZATIONS, OR BUSINESS GROUPS.

OVERVIEW OF OIG

THE OFFICE OF INSPECTOR GENERAL (OIG) HAS A STATUTORY RESPONSIBILITY TO PROTECT THE INTEGRITY OF DEPARTMENTAL PROGRAMS AS WELL AS THE HEALTH AND WELFARE OF BENEFICIARIES SERVED BY THOSE PROGRAMS. THROUGH OUR COMPREHENSIVE PROGRAM OF AUDITS, INSPECTIONS, PROGRAM EVALUATIONS, AND INVESTIGATIONS, WE PROMOTE ECONOMY, EFFICIENCY AND EFFECTIVENESS IN THE DEPARTMENT'S PROGRAMS AND PREVENTION OF FRAUD, WASTE, AND ABUSE. OUR REPORTS CONTAIN INFORMATION ON THE EFFECTIVENESS OF THE DEPARTMENT'S

PROGRAMS, AND MAKE TIMELY RECOMMENDATIONS THAT REDUCE EXCESSIVE EXPENDITURES OR CORRECT SYSTEMIC WEAKNESSES.

FY 1990 MARKED OUR TENTH CONSECUTIVE ANNUAL INCREASE IN PROSECUTORIAL ACCOMPLISHMENTS. OF THE APPROXIMATELY 2,200 SUCCESSFUL CRIMINAL AND ADMINISTRATIVE PROSECUTIONS WE ATTAINED LAST YEAR, NEARLY HALF WERE DIRECTLY RELATED TO THE HEALTH CARE FINANCING PROGRAMS. THESE INDIVIDUALS AND ENTITIES HAD DEFRAUDED OR ABUSED THE HEALTH CARE PROGRAMS OR THEIR BENEFICIARIES.

WE HAVE LONG RECOGNIZED THE FINANCIAL DIFFICULTIES FACING THE MEDICARE TRUST FUNDS. WE HAVE MADE A NUMBER OF RECOMMENDATIONS TO IMPROVE THE SOLVENCY OF THE FUNDS. IN 1990 ALONE, ALMOST $2 BILLION IN SETTLEMENTS, FINES, RESTITUTIONS, RECEIVABLES, AND SAVINGS TO THE MEDICARE PROGRAM RESULTED FROM OIG ACTIVITIES AND IMPLEMENTATION OF OIG RECOMMENDATIONS. OVER THE LAST 5-YEAR BUDGET CYCLE, APPROXIMATELY $28 BILLION IN SAVINGS, SETTLEMENTS, FINES, RESTITUTIONS, AND RECEIVABLES HAVE RESULTED FROM OUR WORK. IN ADDITION, THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (OBRA '90) CONTAINS ABOUT $29 BILLION IN 5-YEAR MEDICARE SAVINGS THAT PERTAIN TO OUR RECOMMENDATIONS. WE STILL HAVE PENDING RECOMMENDATIONS THAT, IF IMPLEMENTED, COULD RESULT IN BILLIONS MORE IN ANNUAL SAVINGS WITHOUT ADVERSELY AFFECTING ACCESS OR QUALITY OF CARE FOR OUR BENEFICIARIES.

UNDER OUR ENABLING LEGISLATION, WE ARE RESPONSIBLE FOR OVERSIGHT OF THE DEPARTMENT'S MANAGEMENT ACTIVITIES. THE OIG IS MANDATED TO INDEPENDENTLY REVIEW THE EFFECTIVENESS AND EFFICIENCY OF HHS PROGRAMS AND ACTIVITIES AND TO PROVIDE MANAGEMENT WITH RECOMMENDATIONS FOR IMPROVEMENT.

INTEGRAL TO THIS RESPONSIBILITY IS OUR ROLE IN THE DEPARTMENT'S IMPLEMENTATION OF THE FEDERAL MANAGER'S FINANCIAL INTEGRITY ACT (FMFIA) OF 1982. THROUGH OUR AUDITS AND INSPECTIONS, WE IDENTIFY DEFICIENCIES IN THE DEPARTMENT'S PROGRAMS, INCLUDING DEFICIENCIES THAT CONSTITUTE A "MATERIAL WEAKNESS" UNDER THE FMFIA. THE ACT REQUIRES AGENCY HEADS TO REPORT ANNUALLY ON THE STATUS OF THE DEPARTMENT'S INTERNAL CONTROLS AND ACCOUNTING SYSTEMS TO THE PRESIDENT AND THE CONGRESS AND PROVIDES FOR THE DISCLOSURE OF MATERIAL WEAKNESSES. THE ACT PROVIDES THE NECESSARY GOVERNMENTWIDE DISCIPLINE TO IDENTIFY AND REMEDY LONG-STANDING PROBLEMS THAT HAMPER EFFECTIVENESS AND ACCOUNTABILITY, POTENTIALLY COSTING THE TAXPAYERS BILLIONS OF DOLLARS, AND ERODE THE PUBLIC'S CONFIDENCE IN GOVERNMENT. THE VAST MAJORITY OF SUCH WEAKNESSES REPORTED BY OUR DEPARTMENT WERE IDENTIFIED BY THE OIG. OVER THE LAST 3 YEARS, 35 MATERIAL WEAKNESSES BROUGHT TO THE ATTENTION TO THE SECRETARY BY THE OIG WERE INCLUDED IN HIS REPORT TO THE PRESIDENT AND THE CONGRESS.

SELECTED ISSUES OF CONCERN

IN ADDITION TO IDENTIFYING POTENTIAL WEAKNESSES IN THE HEALTH CARE FINANCING PROGRAMS, WE CONTINUE TO FOCUS ATTENTION ON THE FUTURE FINANCIAL VIABILITY OF MEDICARE AND MEDICAID. WHILE THE CONGRESS AND THE ADMINISTRATION HAVE BEEN SUCCESSFUL IN CONSTRAINING THE RATE OF GROWTH OF THE MEDICARE PROGRAM, MANY OPPORTUNITIES STILL EXIST TO REALIZE ADDITIONAL PROGRAM SAVINGS.

WE RECENTLY ISSUED A REPORT ENTITLED *OIG's RECOMMENDATIONS IMPACTING ON THE SOLVENCY OF THE MEDICARE TRUST FUNDS*. THE REPORT CONTAINS UNIMPLEMENTED RECOMMENDATION WHICH WOULD ENHANCE

PROGRAM REVENUES, ESTABLISH MORE EQUITABLE PAYMENT POLICIES, AND IMPROVE ENFORCEMENT OF PROGRAM REQUIREMENTS. IF FULLY IMPLEMENTED, THE RECOMMENDATIONS COULD SAVE MEDICARE OVER $10 BILLION IN A YEAR. ABOUT 91 PERCENT OF THE SAVINGS WOULD BE RECURRING.

A COMPREHENSIVE LISTING OF ALL OIG UNIMPLEMENTED LEGISLATIVE RECOMMENDATIONS CAN BE FOUND IN OUR *COST-SAVER HANDBOOK*, COMMONLY CALLED *THE RED BOOK*. ENACTMENT OF THESE UNIMPLEMENTED RECOMMENDATIONS WOULD SAVE ALMOST $30 BILLION ANNUALLY. A COMPREHENSIVE LISTING OF OIG UNIMPLEMENTED MANAGEMENT RECOMMENDATIONS CAN BE FOUND IN OUR *PROGRAM AND MANAGEMENT IMPROVEMENT RECOMMENDATIONS* COMMONLY CALLED *THE ORANGE BOOK*.

IN PREPARING FOR THIS HEARING, YOU ASKED US TO ADDRESS THOSE AREAS IN MEDICARE WHICH WE BELIEVE POSE THE MOST SIGNIFICANT PROBLEMS TO THE PROGRAM FROM SEVERAL PERSPECTIVES: ECONOMY, EFFICIENCY, FRAUD, OR ABUSE. IN THE FOLLOWING PORTION OF MY TESTIMONY, I HAVE LISTED A NUMBER OF ITEMS (SOME OF WHICH PERTAIN TO MORE THAN ONE PERSPECTIVE) THAT WE BELIEVE MERIT FURTHER CONGRESSIONAL ATTENTION.

I. CONTRACTOR REFORM

AS YOU KNOW, HCFA CONTRACTS WITH A NUMBER OF PRIVATE INSURANCE COMPANIES TO HANDLE THE CLAIMS AND DISBURSEMENT OF FUNDS. CONTRACTORS WHO PROCESS CLAIMS UNDER PART A ARE KNOWN AS FISCAL INTERMEDIARIES AND THOSE THAT PROCESS PART B CLAIMS ARE KNOWN AS CARRIERS. EACH CONTRACTOR HAS RESPONSIBILITY FOR PAYMENT OF CLAIMS IN A DESIGNATED GEOGRAPHIC AREA. CURRENTLY THERE ARE ABOUT 82 CONTRACTORS. WE NOTE THAT THE NUMBER OF MEDICARE CLAIMS FILED IS EXPECTED TO DOUBLE TO 1 BILLION CLAIMS ANNUALLY WITHIN THE NEXT DECADE.

THE NECESSITY AND RATIONALE FOR EMPLOYING A MULTIPLICITY OF CONTRACTORS, A SYSTEM ESTABLISHED WHEN THE MEDICARE PROGRAM WAS ESTABLISHED, MAY NO LONGER HOLD TRUE. FIRST, AS MEDICARE MOVES TO PROSPECTIVE PAYMENT AND FEE SCHEDULES (INCLUDING PHYSICIAN SERVICES AND DURABLE MEDICAL EQUIPMENT), THE CONTRACTOR SYSTEM THAT WAS DESIGNED TO TAKE INTO ACCOUNT GEOGRAPHIC VARIATIONS MAY NO LONGER MAKE SENSE. SECOND, ADVANCED COMPUTER TECHNOLOGY MAKE IT FEASIBLE FOR FEWER COMPANIES TO HANDLE LARGER VOLUMES OF CLAIMS. FURTHER, ELECTRONIC CLAIMS PROCESSING ALLOWS INFORMATION TO BE SENT OVER GREAT DISTANCES IN SECONDS. THEREFORE, WE BELIEVE THAT A RE-ANALYSIS, BY THE CONGRESS AND HCFA, OF THE STRUCTURE OF THE CONTRACTING SYSTEM SHOULD BE CONDUCTED AND A CONDENSING OF THE NUMBER OF CONTRACTORS MAY BE WARRANTED.

THIS ANALYSIS SHOULD ALSO CONSIDER THE RATIONALE AND WISDOM OF DIVIDING SERVICES UNDER PART A AND PART B OF THE MEDICARE PROGRAM. MEDICARE PART A AND MEDICARE PART B COMPLEMENT EACH OTHER AND, IN SOME RESPECT, OFFER SUBSTITUTE SERVICES. CHANGES IN MEDICAL TECHNOLOGY HAVE MEANT THAT TREATMENTS WHICH ONCE COULD BE PROVIDED ONLY IN THE INPATIENT SETTING, CAN NOW BE PROVIDED IN THE OUTPATIENT SETTING, OR EVEN IN THE PATIENT'S HOME. IN ADDITION, CHANGES IN MEDICAL PRACTICES, STIMULATED IN PART BY VARIOUS COST CONTAINMENT INITIATIVES, HAVE LED TO A SHIFT OF SOME CARE AWAY FROM THE ACUTE CARE HOSPITAL INPATIENT TO THE OUTPATIENT SETTING. THUS, SOME SERVICES WHICH WERE PREVIOUSLY PERFORMED ON AN INPATIENT BASIS (AND FINANCED BY PART A) ARE NOW BEING PERFORMED ON AN OUTPATIENT BASIS (AND FINANCED BY PART B). THE DISTINCTION BETWEEN PART A AND PART B SERVICES, WHICH MAY HAVE

BEEN CLEAR IN 1965 WHEN THE PROGRAM WAS INTRODUCED, HAS BECOME INCREASINGLY BLURRED OVER TIME.

II. DURABLE MEDICAL EQUIPMENT

MEDICARE PART B COVERS DURABLE MEDICAL EQUIPMENT (DME) WHICH INCLUDES OXYGEN EQUIPMENT, WHEELCHAIRS, TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS), HOME DIALYSIS SYSTEMS, SEAT LIFT MECHANISMS, AND OTHER MEDICALLY NECESSARY EQUIPMENT THAT PHYSICIANS PRESCRIBE FOR HOME USE. WE HAVE DOCUMENTED FRAUDULENT AND ABUSIVE PRACTICES WHICH CONTINUE IN THE DME INDUSTRY, INCLUDING QUESTIONABLE MARKETING TECHNIQUES, INFLATED CHARGES, AND MANIPULATION OF LOOPHOLES IN THE LAW.

A. CARRIER SHOPPING

WE ARE ESPECIALLY CONCERNED WITH THE CONSEQUENCES OF AN INCREASINGLY COMMON PRACTICE IN THE DME AREA WHICH IS CALLED "CARRIER SHOPPING". CARRIER SHOPPING EXISTS BECAUSE (1) UNSCRUPULOUS SUPPLIER'S ARE ABLE TO TAKE ADVANTAGE OF THE HCFA REGULATIONS REGARDING "POINT OF SALE" OR CARRIER JURISDICTION AND (2) BECAUSE GEOGRAPHIC VARIATIONS IN REIMBURSEMENT RATES MAKE IT ECONOMICALLY BENEFICIAL TO CARRIER SHOP.

FIRST, CARRIER SHOPPING FLOURISHES BECAUSE OF HCFA's RULES REGARDING THE POINT OF SALE. IN GENERAL, CARRIER JURISDICTION OVER CLAIMS PAYMENT IS BASED ON EITHER THE LOCATION OF THE DME BUSINESS OR THE POINT OF SALE OF THE SUPPLY OR SERVICE. POINT OF SALE IS DEFINED AS THE POINT AT WHICH THE ORDER FOR THE SERVICE OR SUPPLY IS RECEIVED. TO TAKE ADVANTAGE OF GEOGRAPHIC VARIATIONS IN REIMBURSEMENT RATES, SOME DME COMPANIES LOCATE OFFICES IN STATES WITH THE HIGHEST MEDICARE RATES SOLELY TO INCREASE PROFITS. OTHERS HAVE DEVELOPED SCHEMES WHICH, COUPLED WITH MODERN TELEPHONE TECHNOLOGY, MAKE IT APPEAR THAT THEY ARE LOCATED IN LOCALITIES THAT PAY A HIGHER REIMBURSEMENT RATE. COMMON TACTICS EMPLOYED INCLUDE THE USE OF TOLL FREE TELEPHONE NUMBER, MAIL DROPS, AND CALL FORWARDING.

WE HAVE RECOMMENDED THAT HCFA CHANGE THE REGULATION CONCERNING THE POINT OF SALE. THIS CHANGE WOULD REQUIRE THAT PAYMENT BE MADE BY THE CARRIER SERVICING THE AREA IN WHICH THE BENEFICIARY RESIDES. THE PROCESSING OF CLAIMS BY THE BENEFICIARY'S LOCAL CARRIER WILL DETER MOST OF THE CARRIER SHOPPING SCHEMES THAT HAVE EVOLVED OVER THE LAST FEW YEARS.

SECOND, CARRIER SHOPPING OCCURS BECAUSE HCFA's CURRENT REIMBURSEMENT METHODOLOGY ALLOWS FOR SIGNIFICANT VARIATIONS FROM STATE TO STATE IN THE AMOUNTS PAID FOR SIMILAR SERVICES OR SUPPLIES. THESE WIDE DIFFERENCES ARE NOT EXPLAINED BY COST DIFFERENCES AMONG GEOGRAPHIC AREAS NOR ARE THEY REASONABLE. FOR EXAMPLE, A BOX OF 30 OSTOMY POUCHES MAY BRING $55 IN KANSAS AND $185 IN PENNSYLVANIA FROM THEIR RESPECTIVE CARRIERS. FURTHER, THE KANSAS CARRIER MAY ONLY PAY FOR THE EQUIVALENT OF 1 BOX PER BENEFICIARY PER MONTH, WHILE THE PENNSYLVANIA CARRIER MAY NOT LIMIT THE NUMBER OF POUCHES PER MONTH FOR WHICH THEY WILL PAY.

OBRA '90 CORRECTED SOME DME DEFICIENCIES BY MANDATING A NATIONWIDE INDEX THAT WILL PERMIT NO MORE THAN A 15 PERCENT DIFFERENCE IN THE AMOUNT OF ALLOWED CHARGES ANYWHERE IN THE COUNTRY. ALTHOUGH THIS WILL HAVE THE EFFECT OF LIMITING DEVIATIONS AND INDIVIDUAL AREA ABUSES, IT WILL ALSO HAVE THE UNINTENDED EFFECT OF RAISING PAYMENTS BY CARRIERS WHO HAD PREVIOUSLY MAINTAINED LOW REIMBURSEMENT RATES.

TO CORRECT THESE DEFICIENCIES, WE BELIEVE A NATIONAL SINGLE PRICING SCHEDULE SHOULD BE ESTABLISHED FOR ALL DME THAT COULD TAKE INTO CONSIDERATIONS LOCAL MARKET VARIATIONS. WE ALSO BELIEVE THAT HCFA SHOULD DEVELOP ADEQUATE DEFINITIONS FOR DME SUPPLIES AND EQUIPMENT.

B. HIGH PRESSURE MARKETING

SOME DME COMPANIES EMPLOY INTENSE, HIGH PRESSURE MARKETING PRACTICES TO COERCE BENEFICIARIES INTO ORDERING UNNEEDED EQUIPMENT. IN ADVERTISEMENTS THROUGH TELEVISION, RADIO, OR MASS MAILINGS, BENEFICIARIES ARE TOLD THAT CERTAIN EQUIPMENT CAN BE SUPPLIED IN THEIR HOMES AT NO CHARGE TO THEM. MORE AGGRESSIVE TECHNIQUES INCLUDE TELEMARKETING. BENEFICIARIES ARE CONTACTED BY TELEPHONE BY HIGH PRESSURE SALESMEN WHO TAKE ADVANTAGE OF BENEFICIARIES WITH MISREPRESENTATIONS AND CONFUSING SALES PITCHES. MANY TIMES BENEFICIARIES ARE TOLD THAT MEDICARE WANTS THEM TO HAVE THE EQUIPMENT, REGARDLESS OF CURRENT NEED. ONCE THE COMPANIES OBTAIN THE NAME OF THE BENEFICIARY'S PRIMARY PHYSICIAN THEY THEN PRESSURE THE PHYSICIAN TO SIGN THE CERTIFICATE OF MEDICAL NECESSITY (CMN) BY THREATENING THAT FAILURE TO SIGN COULD RESULT IN PATIENTS SEEKING OTHER PHYSICIANS.

MANY TIMES THE PHYSICIANS MERELY SIGN THESE CMNs WITHOUT QUESTION. IN OTHER INSTANCES, DME COMPANIES DELIVER EQUIPMENT BEFORE MEDICAL APPROVAL IS GIVEN AND LATER REPOSSESS THE EQUIPMENT IF THE CMNs ARE NOT SIGNED BY THE PHYSICIAN. EVEN IF THE PATIENT'S PHYSICIAN OBJECTS TO A DME SUPPLIER'S REQUEST FOR APPROVAL OF A PIECE OF EQUIPMENT, SOME DME COMPANIES WILL EITHER ENLIST A CO-CONSPIRATOR PHYSICIAN TO SIGN THE FORM OR EVEN FORGE THE PHYSICIAN'S SIGNATURE. ALSO, THE CMN MAY BE ALTERED AFTER THE PHYSICIAN HAS SIGNED IT, TO INCLUDE EQUIPMENT FOR WHICH THE PATIENT HAS NO NEED, OR TO INCLUDE FALSE DIAGNOSES.

UNDER OBRA '90, SUPPLIERS ARE PROHIBITED FROM PROVIDING PHYSICIANS OR BENEFICIARIES WITH COMPLETED OR PARTIALLY COMPLETED CMNs. HOWEVER, WE HAVE NOTICED SEVERAL DME SUPPLIERS SENDING CMNs TO PHYSICIANS WITH NOTES ATTACHED EXPLAINING HOW TO COMPLETE EACH BLOCK OF THE FORM, IN ORDER TO ENSURE MEDICARE WILL PAY FOR THE ITEMS BEING SOLD. THESE PROVISIONS WERE SUPPOSED TO GO INTO EFFECT ON JANUARY 1, 1991. HCFA HAS NO IMMEDIATE PLANS TO PURSUE IMPLEMENTATION.

THESE HIGH PRESSURE MARKETING TECHNIQUES ARE USED IN OTHER AREAS THAN DME. FOR EXAMPLE, MEDICARE BENEFICIARIES ARE GIVEN A "FREE" CHOLESTEROL OR OTHER MEDICAL TEST. AFTER THE FREE TEST, THE BENEFICIARIES ARE TOLD THAT THEY HAVE CONDITIONS REQUIRING FURTHER TESTING -- AT NO COST TO THEM IF THEY PROVIDE A MEDICARE OR OTHER INSURANCE NUMBER. MANY ARE REFERRED TO MOBILE LABORATORIES FOR FURTHER TESTING, WHERE THEY ARE PRESSURED INTO UNDERGOING COSTLY, UNNECESSARY TESTS, SUCH AS VASCULAR AND X-RAY EXAMINATIONS. MEDICARE AND PRIVATE INSURANCE COMPANIES ARE THEN BILLED HUNDREDS OF THOUSANDS OF DOLLARS IN CHARGES FOR THESE ADDITIONAL TESTS. OFTEN, THESE TESTS ARE NOT ACTUALLY PERFORMED.

III. MEDICARE AS SECONDARY PAYER

AS THE SUBCOMMITTEE MEMBERS WELL KNOW, THE OIG HAS AGGRESSIVELY REVIEWED MEDICARE SECONDARY PAYER (MSP) ISSUES. OUR REVIEWS HAVE SHOWN THAT THE SYSTEM USED TO IDENTIFY MEDICARE BENEFICIARIES WHO HAVE EMPLOYER-SPONSORED HEALTH INSURANCE NEEDS TO BE STRENGTHENED. NUMEROUS STUDIES BY OIG, HCFA, AND GAO HAVE

DOCUMENTED THE DEFICIENCIES IN THE MSP PROGRAM. WE HAVE ESTIMATED THAT MISTAKEN MSP PAYMENTS TOTALLED $600 MILLION IN 1988. HCFA ESTIMATES THAT MISTAKEN MSP PAYMENTS WILL TOTAL $900 MILLION IN 1990 AND $1.3 BILLION IN 1991.

HHS's 1990 FMFIA REPORT TO THE PRESIDENT AND CONGRESS CONTINUED TO LIST MSP AS A MATERIAL WEAKNESS. WE BELIEVE THAT ADDITIONAL LEGISLATIVE ACTION IS NECESSARY TO CORRECT THE DEFICIENCIES IN THE MSP PROGRAM. THE CURRENT IRS/SSA/HCFA DATA MATCH (MANDATED BY OBRA '89 AND EXTENDED BY OBRA '90) IS A RETROACTIVE MECHANISM FOR RECOUPING MISTAKEN MSP PAYMENTS AND WILL SUNSET IN 1995. THE PRESIDENT'S FY 1992 BUDGET CONTAINS A PROPOSAL TO ESTABLISH A "CLEARINGHOUSE" OF HEALTH INSURANCE INFORMATION WHICH WOULD BE COLLECTED BY MODIFYING THE W-2 FORMS. SUCH A MODIFICATION HAD PREVIOUSLY BEEN RECOMMENDED BY OUR OFFICE. OTHER OPTIONS RECOMMEND BY OUR OFFICE INCLUDE:

- HCFA SHOULD REVISE ALL MEDICARE CLAIM FORMS TO REQUIRE AN ANSWER OF "YES" OR "NO" TO THE QUESTION, "DO YOU HAVE HEALTH INSURANCE AS A RESULT OF YOUR, OR YOUR SPOUSE'S CURRENT EMPLOYMENT?"

- HCFA SHOULD ALSO AMEND INSTRUCTIONS TO MEDICARE CONTRACTORS TO SPECIFY THAT IF THE SECTION ON THE CLAIM FORM PERTAINING TO EMPLOYEE INSURANCE COVERAGE IS BLANK, THE CLAIM SHOULD BE SUSPENDED AND RETURNED TO THE SENDER WITH A NOTE EXPLAINING THAT THE ITEM ON OTHER HEALTH INSURANCE COVERAGE MUST BE ANSWERED.

- HCFA SHOULD COORDINATE WITH SSA TO MAINTAIN, AS PART OF THE MASTER BENEFICIARY RECORD SYSTEM, ACCURATE BENEFICIARY SPOUSAL INFORMATION. THIS SPOUSAL INFORMATION SHOULD THEN BE REPORTED TO HCFA FOR USE IN MSP ACTIVITIES.

WE BELIEVE THAT THE ADOPTION OF THESE RECOMMENDATIONS WOULD PREVENT A SIGNIFICANT AMOUNT OF MSP OVERPAYMENTS.

IV. REIMBURSEMENT MANIPULATION

MANY FRAUDULENT BILLINGS INVOLVE THE ARTFUL MANIPULATION OF HCFA REIMBURSEMENT RULES AND REGULATIONS. THREE COMMON TYPES OF CODING MANIPULATION ARE: (1) UNBUNDLING OR BILLING COMPONENT PARTS AS SEPARATE PROCEDURES; (2) UPCODING; AND (3) RECOVERY BILLING.

A. UNBUNDLING

"UNBUNDLING" IS A WIDESPREAD PRACTICE AMONG DOCTORS, HOSPITALS, AND OTHER HEALTH CARE PROVIDERS. USING THIS PRACTICE, CLAIMS FOR MEDICAL SUPPLIES ARE INFLATED FAR ABOVE THEIR ACTUAL COST BY BILLING FOR COMPONENT PARTS.

OSTOMY POUCHES CAN SERVE TO ILLUSTRATE THIS POINT. AN OSTOMY POUCH PURCHASED FROM A DME SUPPLIER COSTS ABOUT $4, DEPENDING ON LOCATION. THESE POUCHES CONSIST OF THE POUCH ITSELF, AN ATTACHED SKIN BARRIER, AND ADHESIVE. HOWEVER, IF A CLAIM WERE FILED FOR EACH INDIVIDUAL ITEM SEPARATELY, THE TOTAL COST WOULD BE ABOUT $10.50, APPROXIMATELY 2 1/2 TIMES HIGHER THAT THE ITEM ACTUALLY PROVIDED. ANOTHER EXAMPLE OF UNBUNDLING IS BILLING A HYSTERECTOMY AS A NUMBER OF SEPARATE PROCEDURES -- FOR EXAMPLE, EXPLORATION OF THE ABDOMEN, REMOVAL OF OVARIES AND TUBES, AND REMOVAL OF SCAR TISSUE. THESE TYPES OF TECHNIQUES CAN RESULT IN UNDESERVED PAYMENTS OF MILLIONS OF DOLLARS.

THESE PRACTICES MAY BE ILLEGAL AND ARE CERTAINLY ONE OF THE REASONS THE COSTS TO THE MEDICARE PROGRAM ARE UNNECESSARILY INFLATED. UNTIL REGULATIONS ARE MODIFIED, MANY UNBUNDLING PRACTICES WILL CONTINUE TO BE ALLOWABLE UNDER MEDICARE GUIDELINES.

IN A RECENT REVIEW OF ONE LARGE MEDICARE CONTRACTOR AND ONE MEDICAID STATE AGENCY, WE FOUND THAT PHYSICIANS ARE UNBUNDLING PROCEDURE CODES TO INCREASE PAYMENTS FROM MEDICARE AND MEDICAID.

OUR SAMPLE OF 1990 PAYMENTS INCLUDED OVER 134,000 MEDICARE SURGICAL CLAIMS AND OVER 8,000 MEDICAID SURGICAL CLAIMS SUBMITTED BY PHYSICIANS. IN OUR TESTS FOR PROCEDURE UNBUNDLING IN SURGICAL CODES IN THE MEDICARE CLAIMS, WE FOUND THAT 3 PERCENT OF ALL SINGLE SURGERY AND 28 PERCENT OF ALL MULTIPLE SURGERY CLAIMS CONTAINED A CODING MANIPULATION OR OVERPAYMENT PROBLEM. THIS COULD AMOUNT TO OVER $9 MILLION ANNUALLY AT ONE MEDICARE CONTRACTOR.

OVERALL, THE POTENTIAL FOR ANNUAL OVERPAYMENTS AT ONE CARRIER COULD AMOUNT TO NEARLY $13 MILLION IN MEDICARE PART B AND OVER $1 MILLION IN MEDICAID AT ONE STATE. MULTIPLY THIS BY THE NUMBER OF CLAIMS PROCESSED BY ALL MEDICARE CARRIERS AND MEDICAID STATE AGENCIES, AND ONE CAN RECOGNIZE THE SIGNIFICANT IMPACT THIS HAS ON THE RISING COSTS OF FEDERAL HEALTH CARE. WE PLAN ON EXPANDING OUR STUDY.

B. UPCODING

UPCODING IS A RELATIVELY SIMPLE PROCESS OF BILLING A SERVICE USING A CODE FOR SIMILAR, BUT SLIGHTLY MORE COMPLEX SERVICE. THIS RESULTS IN A HIGHER REIMBURSEMENT RATE THAN IS ACTUALLY APPROPRIATE FOR THE SERVICE WHICH WAS ACTUALLY RENDERED. FOR EXAMPLE, SAYING A PATIENT HAD A STROKE ("A CEREBROVASCULAR ACCIDENT" OR CVA) INSTEAD OF A LESS-SERIOUS TRANSIENT ISCHEMIC ATTACK WOULD MEAN APPROXIMATELY $1,450 IN ADDITIONAL PAYMENT TO THE AVERAGE HOSPITAL. SIMILARLY, CALLING THE REMOVAL OF A SMALL WEDGE OF TISSUE (FOR A BIOPSY) A "RESECTION" COULD MEAN AS MUCH AS $9,000 OVERPAID.

A 1988 OIG STUDY OF 7,050 HOSPITAL RECORDS IDENTIFIED A 20.8 PERCENT RATE OF MISCODING (BOTH INFLATING AND UNDERREPORTING), WITH MORE THAN 60 PERCENT OF THE ERRORS RESULTING IN HIGHER PAYMENTS TO THE HOSPITAL. THE NET EFFECT ON PAYMENT WAS A PROJECTED NATIONAL OVERPAYMENT OF $308 MILLION IN 1985. WE ARE CURRENTLY UPDATING THIS WORK, USING A NEWER SAMPLE OF CASES.

C. RECOVERY BILLING

IN RECOVERY BILLING, CONSULTANTS REVIEW PROVIDER RECORDS OVER A SPECIFIED PERIOD AND IDENTIFY "UNBILLED SERVICES." THE BILLING AGENT TYPICALLY AUDITS PATIENT RECORDS TO IDENTIFY SERVICES FOR WHICH THE PROVIDER HAD FAILED TO BILL. WHILE SUCH ACTION IS PERFECTLY LEGAL, OTHER ACTIVITIES OF THE CONSULTANTS ARE ILLEGAL AND UNETHICAL. THESE OTHER ACTIVITIES INCLUDE "MISINTERPRETING" ENTRIES TO THE RECORDS OR BY SIMPLY MAKING THEM UP, UPCODING, AND UNBUNDLING. THESE UNBILLED SERVICES ARE SUBMITTED TO THIRD PARTY PAYERS FOR REIMBURSEMENT.

AS INVESTIGATORS FOR FRAUD AND ABUSE IN THE HEALTH CARE AREA, WE ARE SEEING NUMEROUS INSTANCES OF FRAUDULENT RECOVERY BILLING. WE CURRENTLY HAVE ABOUT 35 CASES IN THIS AREA. IN ADDITION TO COSTING PATIENTS, INSURANCE COMPANIES, AND THE MEDICARE PROGRAM MILLIONS OF DOLLARS, OUR CONCERNS WITH THESE BILLINGS TAKE ON ALARMING AND

NEW MEANING IN LIGHT OF THE GROWING SOPHISTICATION BEING DEMONSTRATED BY THOSE SUBMITTING RECOVERY BILLINGS TO MEDICARE.

V. HOSPITAL ISSUES

A. HOSPITAL CAPITAL

UNDER EXISTING LAW, MEDICARE IS REQUIRED TO REIMBURSE HOSPITAL FOR CAPITAL COSTS ON A PERSPECTIVE BASIS STARTING IN FY 1992. HCFA HAS ISSUED PROPOSED REGULATIONS TO CREATE SUCH A SYSTEM FOR PUBLIC COMMENT. WE ARE CURRENTLY REVIEWING THE PROPOSED METHODOLOGY TO ENSURE THAT THE PROSPECTIVE AMOUNTS ARE BASED UPON ACCURATE DATA AND TO ENSURE THAT THE RATES WILL ENCOURAGE RATIONAL ECONOMIC BEHAVIOR ON THE PART OF PROVIDERS.

B. CREDIT BALANCES

WE HAVE CONDUCTED INSPECTIONS OF HOSPITAL MEDICAID CREDIT BALANCES SINCE 1985. OUR WORK FOUND THE POTENTIAL FOR SUBSTANTIAL MEDICAID CREDIT BALANCES NATIONWIDE. A 1987 STUDY OF 5 STATES FOUND THAT IF THE SAME CONDITIONS EXISTED IN ALL 50 STATES, THE TOTAL CREDIT BALANCES TO THE MEDICAID PROGRAM COULD BE AS MUCH AS $34 MILLION ($20 MILLION FEDERAL SHARE). WE HAVE RECOMMENDED THAT HCFA TAKE ACTION TO HAVE STATE AGENCIES REPORT CREDIT BALANCES TO HCFA WITHIN 45 DAYS FROM THEIR OCCURRENCE AND THAT HCFA SHOULD ENFORCE THE COBRA REQUIREMENT FOR REFUNDS.

RECENTLY, WE INITIATED A REVIEW OF THE FINANCIAL RECORDS OF HOSPITALS TO DETERMINE WHETHER HOSPITALS HAD BEEN OVERPAID BY THE MEDICARE PROGRAM AND HAD NOT RETURNED THE FUNDS. THESE POTENTIAL OVERPAYMENTS ARE IDENTIFIED ON THE HOSPITAL RECORDS AS CREDIT BALANCES IN THEIR ACCOUNTS RECEIVABLE LEDGERS. MEDICARE REGULATIONS REQUIRE THAT A PROVIDER RETURN THE OVERPAYMENT TO AN INTERMEDIARY WITHIN 60 DAYS OF THE IDENTIFICATION OF THE OVERPAYMENT.

IT IS APPARENT FROM OUR ONGOING REVIEW THAT THE MAJORITY OF HOSPITALS, AFTER POSTING MEDICARE CREDIT BALANCES, MAKE NO FURTHER EFFORT TO DETERMINE HOW MEDICARE OUTPATIENT CREDIT BALANCE ACCOUNTS OCCURRED AND IF MEDICARE IS OWED MONEY. WE PLAN TO REVIEW ADDITIONAL HOSPITALS SERVICED BY 10 INTERMEDIARIES. TO DATE, OUR REVIEWS AT 19 OF HOSPITALS HAVE UNCOVERED ABOUT $1.5 MILLION OF MEDICARE PAYMENTS WHICH HAVE NOT BEEN RETURNED TO THE FEDERAL GOVERNMENT. THESE OVERPAYMENTS RESULTED FROM (1) HOSPITALS SUBMITTING DUPLICATE CLAIMS THAT WENT UNDETECTED BY THE INTERMEDIARY; (2) HOSPITALS BILLING MEDICARE AND A COMMERCIAL INSURER FOR THE SAME SERVICE AND RECEIVING PAYMENT FROM BOTH; AND (3) HOSPITALS BILLING FOR SERVICES NOT PERFORMED.

CURRENTLY, HOSPITALS HAVE NO INCENTIVE TO IDENTIFY MEDICARE OVERPAYMENTS AND REFUND THEM TO THE INTERMEDIARIES. THIS IS BECAUSE INTERMEDIARIES ARE NOT DETECTING MEDICARE OVERPAYMENTS RESULTING FROM MEDICARE OUTPATIENT CREDIT BALANCE ACCOUNTS. EVEN IF INTERMEDIARIES WERE DETECTING THESE OVERPAYMENTS, THE HOSPITALS ARE LIABLE FOR NO MORE THAN THE AMOUNT OF THE ORIGINAL OVERPAYMENT. UNDER THE WORST SCENARIO, HOSPITALS HAVE FREE USE OF FEDERAL FUNDS FOR HOWEVER LONG IT TAKES INTERMEDIARIES, IF EVER, TO DETECT OVERPAYMENTS.

WE ARE, OF COURSE, RECOMMENDING THAT THE HOSPITALS REFUND TO THE INTERMEDIARIES ALL OF THE MEDICARE OVERPAYMENTS THAT WE IDENTIFY THROUGH AUDITS. WE ARE ALSO RECOMMENDING THAT INTERMEDIARIES BE REQUIRED TO REVIEW MEDICARE OUTPATIENT CREDIT BALANCE ACCOUNTS. PERHAPS THE MOST EFFECTIVE METHOD OF ENSURING THAT HOSPITALS

REFUND MEDICARE OVERPAYMENTS TO INTERMEDIARIES IS TO PENALIZE THEM IF THEY DO NOT. CHARGING HOSPITALS INTEREST FOR USE OF MEDICARE FUNDS FOR THE PERIOD 60 DAYS AFTER ESTABLISHMENT OF THE CREDIT BALANCE TO THE ACTUAL DATE THAT A REFUND IS MADE TO THE INTERMEDIARY MAY PROVIDE HOSPITALS THE INCENTIVE THEY APPARENTLY NEED TO PAY MEDICARE WHAT IS RIGHTFULLY OWED TO THE PROGRAM.

VI. PROVIDER NUMBERS

MEDICARE CARRIERS ASSIGN PROVIDER NUMBERS TO PROVIDERS OF PART B SERVICES WHO FURNISH SERVICES OR SUPPLIES TO MEDICARE BENEFICIARIES. PROVIDER NUMBERS ARE USED FOR PROCESSING CLAIMS AND ESTABLISHING PRICING AND UTILIZATION PROFILES. THE PROVIDER OF SERVICES MUST HAVE A PROVIDER NUMBER IN ORDER TO RECEIVE PAYMENT FOR SERVICES.

UNFORTUNATELY, ALMOST ANYONE WHO WANTS A PROVIDER NUMBER CAN OBTAIN ONE. IN ADDITION, A PROVIDER CAN OBTAIN MORE THAN ONE NUMBER. IN SOME STATES, IT'S NOT EVEN NECESSARY TO FILL OUT AN APPLICATION -- ONCE A CLAIM IS SUBMITTED, A PROVIDER NUMBER IS AUTOMATICALLY ASSIGNED. THIS CAN RESULT IN DUPLICATE BILLINGS FOR THE SAME SERVICE OR PRODUCT UNDER DIFFERENT PROVIDER NUMBERS. ALSO, IF A PROVIDER IS CONVICTED OF FRAUD OR ADMINISTRATIVELY EXCLUDED FROM MEDICARE UNDER ONE NUMBER, THEY CAN RE-ENTER THE SYSTEM UNDER A NUMBER WHICH THEY HAD OBTAINED EARLIER FOR "A RAINY DAY."

OUR FRAUD INVESTIGATIONS HAVE CONSISTENTLY DEMONSTRATED THAT THE PRESENT SYSTEM USED BY HCFA TO ISSUE PROVIDER NUMBERS VARIES WIDELY FROM CARRIER TO CARRIER, WITH THE MAJORITY OF CARRIERS REQUIRING MINIMAL INFORMATION FROM THE PROVIDER. HCFA IS AWARE THAT MEDICARE IS VULNERABLE TO PROVIDERS WHO HAVE BEEN SANCTIONED FROM THE PROGRAM AND SUBSEQUENTLY RELOCATE TO OTHER STATES OR SIMPLY RE-ESTABLISH THEMSELVES UNDER A NEW BUSINESS NAME.

HCFA NOW ASSIGNS, THROUGH A NATIONAL REGISTRY, A UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN) FOR EACH PHYSICIAN WHO PROVIDES MEDICARE SERVICES. HOWEVER, THE UPIN DOES NOT ADDRESS SUPPLIERS WHO BILL THE PROGRAM UNDER PART B. WE HAVE RECOMMENDED THAT HCFA DEVELOP A CONTRACTOR PERFORMANCE EVALUATION PROGRAM (CPEP) STANDARD FOR THE PROVIDER NUMBER ASSIGNMENT FUNCTION. THIS WOULD HELP ASSURE THAT, BEFORE ISSUING A PROVIDER NUMBER, THE CARRIER HAS ADEQUATE DOCUMENTATION ON EACH PROVIDER NUMBER ASSIGNMENT. THE STANDARD SHOULD INCLUDE SUCH THINGS AS VERIFYING THE PROVIDER'S QUALIFICATIONS WHERE APPROPRIATE, HAVING ADEQUATE SYSTEMS CONTROLS TO IDENTIFY ALL NUMBERS ASSIGNED TO A PARTICULAR PROVIDER, UPDATING THE FILES ANNUALLY, AND IDENTIFYING THE OWNERSHIP OF ALL ENTITIES WHO HAVE A PROVIDER NUMBER TO ENSURE SANCTIONED INDIVIDUALS ARE NOT BEING PAID. HCFA HAS STATED THAT THEY ARE CONSIDERING APPROACHES TO RESOLVE THIS BUT ARE NOT READY TO ACT ON THEM YET.

VII. PEER REVIEW ORGANIZATIONS

IN AN EFFORT TO CURB RISING HOSPITAL COSTS WHILE ENSURING THAT MEDICARE BENEFICIARIES RECEIVE HIGH-QUALITY MEDICAL CARE, THE CONGRESS ESTABLISHED THE PEER REVIEW ORGANIZATION (PRO) PROGRAM THROUGH THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982. PROs, WHICH BEGAN OPERATING IN 1984, REVIEW HOSPITAL RECORDS FOR ABOUT ONE-FOURTH OF ALL MEDICARE PATIENT ADMISSIONS. MEDICALLY TRAINED PERSONNEL, USUALLY REGISTERED NURSES OR ACCREDITED MEDICAL

RECORDS TECHNICIANS, INITIALLY SCREEN CASES FOR INSTANCES OF UNNECESSARY OR POOR QUALITY CARE. THESE CASES ARE THEN REFERRED TO PHYSICIANS FOR REVIEW. THE PRO DESIGNATED FOR EACH STATE IS RESPONSIBLE FOR DECIDING WHETHER CARE IS REASONABLE AND NECESSARY, IS PROVIDED IN THE APPROPRIATE SETTING, AND MEETS THE STANDARDS OF QUALITY ACCEPTED BY THE MEDICAL PROFESSION. WE ALSO NOTE THAT PROs ARE CHARGED WITH IDENTIFYING UPCODING IN HOSPITAL RECORDS.

SEVERAL OIG AUDITS AND INSPECTIONS HAVE STUDIED POTENTIAL VULNERABILITIES OF THE PRO PROGRAM. IN 1986, AN AUDIT REVEALED INORDINATELY HIGH PROFITS ON PRO CONTRACTS. WHICH WERE ATTRIBUTED TO THE COMBINATION OF FIXED PRICE CONTRACTING AND LITTLE PRO REVIEW ACTIVITY. IN 1988 AND 1989, A SERIES OF THREE OIG INSPECTIONS CRITICIZED PRO SANCTION ACTIVITY, QUALITY REVIEW AND PROGRAM EFFECTIVENESS. IN 1990, AN OIG INSPECTION OF 1985 PRO CODING FOUND THAT THEIR RE-ANALYSIS OF MEDICARE BILLS FAILED TO DETECT UPCODING, DECREASED OVERALL REIMBURSEMENT ACCURACY, AND INCREASED OVERPAYMENTS TO HOSPITALS. WE HOPE THAT ENACTMENT OF THE FOURTH PRO SCOPE OF WORK, WHICH REPRESENTS A MAJOR DEPARTURE FROM PREVIOUS SCOPES OF WORK, WILL CORRECT SOME OF THE DEFICIENCIES IN THE PRO PROGRAM.

WE HAVE ALSO MADE A NUMBER OF RECOMMENDATIONS TO IMPROVE SANCTION ACTIVITY OVER THE YEARS. THESE RECOMMENDATIONS WOULD ALLOW FOR SHARING OF INFORMATION ON PROVIDERS WHO PROVIDE SUBSTANDARD CARE, AND ALLOW FOR MORE FLEXIBLE REMEDIES. WE HAVE RECOMMENDED ENACTING LEGISLATION TO AMEND THE PRO STATUTE TO STRENGTHEN THE CIVIL MONETARY PENALTY TO $10,000 PER VIOLATION.

UNFORTUNATELY, PRO ACTIVITY IN THE SANCTIONS ARE HAS BECOME SO ENCUMBERED BY BUREAUCRATIC PROCESS THAT THEY HAVE BECOME INEFFECTIVE. ONE WAY TO CORRECT THIS DEFICIENCY IS TO ALLOW THE PROs THE AUTHORITY TO SANCTION DIRECTLY, SUBJECT TO REVIEW IN THE COURTS. THIS WILL "UNFREEZE" THE PROs ABILITY TO ACT ON SANCTIONS WHILE ASSURING DUE PROCESS TO PROVIDERS AT RISK OF SANCTION.

FRAUD INVOLVING PROs IS PARTICULARLY SERIOUS, BECAUSE THEY CARRY OUT GREATLY NEEDED FUNCTIONS TO INSURE THE ACCURACY OF MEDICARE PAYMENTS. RECENTLY, THE MEDICARE PRO FOR FLORIDA PLED GUILTY TO SUBMITTING A FALSE STATEMENT TO THE UNITED STATES. THE PRO HAD AUTHORIZED MEDICARE PAYMENTS TO HOSPITALS FOR CASES THEY CLAIMED TO HAVE REVIEWED, WHEN IN FACT NO REVIEW HAD TAKEN PLACE. THE PRO ALSO REVERSED DENIALS OF PAYMENT ON CASES IT CLAIMED TO HAVE REVIEWED BUT ACTUALLY HAD NOT.

WE CURRENTLY HAVE UNDERWAY A STUDY OF THE EDUCATIONAL INTERVENTIONS PROs TAKE WHEN THEY IDENTIFY SERIOUS PROBLEMS WITH THE QUALITY OF MEDICAL CARE DELIVERED TO MEDICARE PATIENTS. VERY FEW PHYSICIANS ARE SANCTIONED, OR EXCLUDED FROM THE MEDICARE AND MEDICAID PROGRAMS. STEPS SHORT OF SANCTIONING CAN INCLUDE MONITORING THE PHYSICIAN MORE CLOSELY, REQUIRING THE PHYSICIAN TO TAKE MORE COURSES TO UPGRADE SKILLS, OR OTHERWISE INTERVENING IN THE WAY THE PHYSICIAN PRACTICES. THIS STUDY, WHICH WILL BE RELEASED SHORTLY, WILL EXAMINE THE TYPES OF INTERVENTIONS PROs USE, AND THE CHARACTERISTICS OF THE PHYSICIANS.

X. HEALTH MAINTENANCE ORGANIZATIONS

RECENTLY, THERE HAVE BEEN NUMEROUS MEDIA REPORTS AND EXPRESSIONS OF CONGRESSIONAL CONCERN REGARDING THE MARKETING PRACTICES OF CERTAIN SOUTH FLORIDA HMOs. BECAUSE OF THESE CONCERNS, WE

CONDUCTED A REVIEW OF MARKETING PRACTICES OF THESE HMOs, INCLUDING ENROLLMENT AND POSSIBLE DISENROLLMENT TECHNIQUES, TO DETERMINE WHETHER THEY ARE WITHIN ACCEPTED GOVERNMENT STANDARDS.

OUR INSPECTION OF MARKETING PRACTICES REVEALED THAT MOST BENEFICIARIES INITIATE THE ENROLLMENT CONTACT WITH THE HMOs AND FEW FELT PRESSURE BY SALES AGENTS; THE HMOs' MARKETING PRACTICES DO NOT ALWAYS MEET HCFA GUIDELINES; SOME ENROLLMENTS DID NOT REPRESENT INFORMED CHOICES; AND BENEFICIARIES DO NOT ALWAYS UNDERSTAND THE "LOCK-IN" CONCEPT.

THE INSPECTION OF BENEFICIARY ENROLLMENT PATTERNS REVEALED THAT BENEFICIARIES IN THE MIAMI AREA ENROLL AND DISENROLL MORE FREQUENTLY THAN ANY OTHER GROUP IN THE NATION. BENEFICIARIES REPORT THAT THEY CHANGE HMOs DUE TO DISSATISFACTION WITH THEIR DOCTORS OR SERVICES, INABILITY TO GET THE DESIRED SPECIALTY CARE, THE LOCATION OF THE HMO, OR BEING ENCOURAGED BY SALESPEOPLE TO CHANGE HMOs. BECAUSE OF THE RESULTS OF THIS STUDY, WE ARE PLANNING A NATIONWIDE DISENROLLMENT STUDY THAT SHOULD BE COMPLETED IN JANUARY 1992.

XI. SITE OF SERVICE DIFFERENTIAL

THE MEDICARE PROGRAM PRESENTLY LIMITS PAYMENT FOR SERVICES PERFORMED IN AN OUTPATIENT SETTING IF THE SERVICE IS "ROUTINELY" PERFORMED IN A PHYSICIAN'S OFFICE. THIS LIMITATION, WHICH IS KNOWN AS THE SITE OF SERVICE DIFFERENTIAL, IS INTENDED TO ENSURE THAT MEDICARE DOES NOT MAKE DUPLICATE PAYMENTS FOR OVERHEAD EXPENSES; ONCE TO THE OUTPATIENT FACILITY AND AGAIN TO THE PHYSICIAN. IT APPLIES TO SERVICES PERFORMED 50 PERCENT OR MORE OF THE TIME IN AN OFFICE SETTING.

WE BELIEVE THAT THE MEDICARE PROGRAM COULD REALIZE SIGNIFICANT SAVINGS BY EXPANDING THE SITE OF SERVICE DIFFERENTIAL TO OTHER LOCATIONS OF SERVICE SUCH AS INPATIENT AND NURSING HOME SETTINGS. IT WOULD ALSO BE EQUITABLE TO ADD AN ANNUAL THRESHOLD, BASED SOLELY ON THE VOLUME OF PROCEDURES, TO HCFA'S DEFINITION. FOR EXAMPLE, PROCEDURE CODE 90620 - COMPREHENSIVE CONSULTATION - WAS PERFORMED OVER 1 MILLION TIMES IN PHYSICIANS' OFFICES, BUT DID NOT APPEAR ON HCFA'S LISTING BECAUSE THE "IN-OFFICE" OCCURRENCES REPRESENTED ONLY 22 PERCENT OF TOTAL VOLUME.

WE BELIEVE USING A THRESHOLD OF PROCEDURES PERFORMED AT LEAST 250,000 TIMES WOULD BE AN APPROPRIATE TEST TO DETERMINE THAT THE PROCEDURE WAS ROUTINELY PERFORMED. WE HAVE IDENTIFIED AT LEAST EIGHT "HIGH VOLUME" PROCEDURE CODES WHICH MEET THIS CRITERIA. IN 1989, THE FREQUENCY OF "IN-OFFICE" SERVICES FOR THESE EIGHT CODES RANGED FROM OVER 300,000 TO NEARLY 1.5 MILLION OCCURRENCES. MOST OF THESE PROCEDURE CODES INVOLVE CONSULTATION VISITS. IF WE TAKE INTO CONSIDERATION THE CHANGES PROPOSED BY HCFA UNDER PHYSICIAN PAYMENT REFORM, THE PAYMENTS FOR THESE PROCEDURES WOULD BE REDUCED BY OVER 20.5 PERCENT WHEN THE SERVICE WAS PERFORMED IN A SETTING OTHER THAN THE PHYSICIAN'S OFFICE. WE ESTIMATE THAT THE BUDGETARY IMPACT OF THESE SAVINGS WOULD BE ABOUT $166 MILLION ANNUALLY.

XI. KICKBACKS

A. PHYSICIAN OWNERSHIP – JOINT VENTURES

PHYSICIAN OWNERSHIP OF AND COMPENSATION FROM ENTITIES TO WHICH THEY MAKE REFERRALS IS A PRACTICE THAT HAS INCREASED CONSIDERABLY IN THE LAST 10 YEARS. MANY PHYSICIANS HAVE FINANCIAL RELATIONSHIPS WITH LABORATORIES, DME SUPPLIERS, NURSING HOMES, AMBULATORY SURGICAL CENTERS, AND HOME HEALTH AGENCIES. AN OIG INSPECTION FOUND THAT PATIENTS OF REFERRING PHYSICIANS WHO OWN OR INVEST IN LABORATORIES RECEIVE CONSIDERABLY MORE SERVICES THAN THE MEDICARE AVERAGE.

RESEARCH CONTINUES TO DETERMINE THE EXTENT TO WHICH INCREASED COSTS ARE A PROBLEM FOR OTHER ITEMS AND SERVICES THAT THESE JOINT VENTURES FURNISH. IN PARTICULAR, WE ARE AWAITING WHAT MAY BE A SIGNIFICANT STUDY EXPECTED TO BE RELEASED THIS SUMMER FROM THE FLORIDA HEALTH COST CONTAINMENT BOARD.

UNDER THE MEDICARE AND MEDICAID ANTI-KICKBACK STATUTE, SECTION 1128B(b) OF THE SOCIAL SECURITY ACT, IT IS ILLEGAL TO OFFER OR PAY A PROFIT DISTRIBUTION TO A PHYSICIAN TO DELIBERATELY INDUCE HIM TO REFER BUSINESS PAYABLE UNDER MEDICARE OR ANY STATE HEALTH CARE PROGRAM. OUR OFFICE HAS INITIATED CIVIL PROSECUTION OF THREE LIMITED PARTNERSHIP LABORATORIES AND ITS PRINCIPALS IN *THE INSPECTOR GENERAL V. THE HANLESTER NETWORK, ET AL.* THE CASE IS PRESENTLY UNDER APPEAL AT THE DEPARTMENT APPEALS BOARD, AND A FINAL DEPARTMENTAL DECISION ON KEY LEGAL ISSUES IS EXPECTED LATE THIS SUMMER.

IN THE VERY NEAR FUTURE, WE HOPE TO PROMULGATE FINAL SAFE HARBOR REGULATIONS. THESE LONG AWAITED REGULATIONS WILL DEFINE FOR HEALTH CARE PROVIDERS SPECIFIC NON-ABUSIVE BUSINESS ARRANGEMENTS THAT WILL NOT BE SUBJECT TO PROSECUTION UNDER THE ANTI-KICKBACK STATUTE. THE REGULATIONS ARE NOW UNDER REVIEW AT THE OFFICE OF MANAGEMENT AND BUDGET. ONE OF THE PROVISIONS WOULD PROVIDE VERY LIMITED PROTECTION TO PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO INVEST IN ENTITIES TO WHICH THEY REFER BUSINESS. THIS TIGHTLY DRAWN SAFE HARBOR, IF ADOPTED, WILL HOPEFULLY LEAD TO A RESTRUCTURING OF MANY JOINT VENTURES AS PROVIDERS FOR THE FIRST TIME WILL BE ABLE TO HAVE THE COMFORT OF KNOWING THAT THEY ARE CONDUCTING BUSINESS LEGALLY.

THE SAFE HARBOR REGULATIONS WILL ALSO FACILITATE PROSECUTION OF THE SERIOUSLY ABUSIVE JOINT VENTURES BECAUSE WE WILL BE ABLE TO SHOW COURTS THAT THOSE WHO CHOOSE TO OPERATE OUTSIDE OF THE SAFE HARBORS ARE CLEARLY ON NOTICE THAT THEIR CONDUCT IS ILLEGAL. WE BELIEVE THAT THE COMBINATION OF CHANGED PROVIDER BEHAVIOR COUPLED WITH MORE EFFECTIVE ENFORCEMENT IS THE BEST THAT CAN BE ACHIEVED UNDER CURRENT LAW.

BASED ON YOUR LEADERSHIP, ANOTHER ENFORCEMENT APPROACH HAS BEEN ADOPTED THAT MAKES IT *PER SE* ILLEGAL, AS OF JANUARY 1, 1992, FOR A PHYSICIAN TO REFER A PATIENT FOR LABORATORY SERVICES TO AN ENTITY IN WHICH HE OR SHE HAS AN OWNERSHIP OR COMPENSATION ARRANGEMENT. THIS BRIGHT LINE APPROACH IS IN CONTRAST TO THE ANTI-KICKBACK STATUTE WHERE THE INSPECTOR GENERAL MUST PROVE KNOWING AND WILLFUL CONDUCT, THE HIGH STANDARD OF PROOF APPLICABLE TO A FRAUD STATUTE.

ONE FEATURE OF THIS NEW LAW IS THAT AS OF JANUARY 1, 1992, THE IDENTITY OF REFERRING PHYSICIANS WILL BE PLACED ON EACH MEDICARE PART B CLAIM. THUS, FOR THE FIRST TIME THE DEPARTMENT WILL BE ABLE TO ROUTINELY COMPILE UTILIZATION DATA THAT ACCURATELY COMPARES REFERRAL PATTERNS OF INVESTORS AND NON-INVESTORS.

WE ANTICIPATE YOUR SUBCOMMITTEE'S INTEREST IN LOOKING INTO THE QUESTION OF EXPANDING THIS *PER SE* PROHIBITION TO OTHER HEALTH CARE ITEMS AND SERVICES FURNISHED BY JOINT VENTURES. WE LOOK FORWARD TO WORKING WITH THE SUBCOMMITTEE AND ITS STAFF, AS WE HAVE DONE IN THE PAST, TO PROVIDE MORE DETAILED ANALYSIS OF OUR ENFORCEMENT EXPERIENCE UNDER THE ANTI-KICKBACK STATUTE AND FURTHER STUDIES AS REQUESTED.

B. ROUTINE WAIVER OF DEDUCTIBLE AND COINSURANCE

UNDER MEDICARE LAW, BENEFICIARIES ARE REQUIRED TO PAY A DEDUCTIBLE PRIOR TO RECEIVING MEDICARE BENEFITS. COINSURANCE, ON THE OTHER HAND, IS A PERCENTAGE AMOUNT THAT THE BENEFICIARY IS REQUIRED TO PAY AFTER A DEDUCTIBLE HAS BEEN MET. SOME PHYSICIANS, DME SUPPLIERS, AND HOSPITAL OUTPATIENT DEPARTMENTS ROUTINELY WAIVE COINSURANCE AND DEDUCTIBLE AMOUNTS UNDER MEDICARE PART B TO LURE BENEFICIARIES INTO ACCEPTING UNNECESSARY SERVICES. THESE CHANGES ARE THEN BILLED AGAINST MEDICARE, GREATLY INCREASING THE MEDICARE PROGRAM COST. IF THE PHYSICIAN OR SUPPLIER IS PAID ON THE BASIS OF CHARGES, AND THE PHYSICIAN OR SUPPLIER DOES NOT ACCURATELY REPORT WHAT THE BENEFICIARY IS ACTUALLY CHARGED, A FALSE CLAIM MAY HAVE BEEN SUBMITTED. WE HAVE ISSUED A SPECIAL FRAUD ALERT TO THE PROVIDER COMMUNITY REGARDING ROUTINE WAIVER OF COINSURANCE AND DEDUCTIBLE AMOUNTS. THE FRAUD ALERT CLEARLY STATES OUR INTENTION TO PURSUE CRIMINAL PROSECUTIONS OF THOSE PROVIDERS WHO OFFER THIS INDUCEMENT.

MEDICAID

BEFORE CONCLUDING, LET ME SAY A FEW WORDS ABOUT ANOTHER ASPECT OF HEALTH CARE -- MEDICAID. THERE ARE A NUMBER OF ISSUES IN THE MEDICAID PROGRAM THAT OUR OFFICE IS PURSUING. THESE ISSUES HAVE THE POTENTIAL OF INCREASING FEDERAL SPENDING IN THE MEDICAID PROGRAMS AND REDUCING ANTICIPATED SAVINGS FROM RECENTLY ENACTED LEGISLATION. THESE ISSUES ARE AS FOLLOWS:

I. STATE TAX AND DONATION PROGRAMS

IN THE LAST SEVERAL YEARS, SOME STATES HAVE FOUND LOOPHOLES IN THE PROGRAM WHICH ALLOW THEM TO TAX AND/OR SEEK DONATIONS FROM MEDICAID PROVIDERS. WE HAVE LOOKED INTO THIS SITUATION VERY THOROUGHLY. BASICALLY, THE STATES USE THESE TAXES AND DONATIONS AS THEIR SHARE OF MEDICAID EXPENDITURES, RESULTING IN ADDITIONAL FEDERAL MATCHING FUNDS FOR THE STATES WITHOUT THE EXPENDITURE OF STATE FUNDS. OUR REPORT ESTIMATES THAT THE COST OF THESE SCHEMES IN 18 STATES COULD COST THE FEDERAL GOVERNMENT ABOUT $2.5 BILLION IN FY 1991 ALONE. WE ARE NOW WORKING WITH THE OFFICE OF MANAGEMENT AND BUDGET TO FURTHER INVESTIGATE HOW MUCH MONEY IS ACTUALLY BEEN LOST THROUGH THESE SCHEMES.

II. MEDICAID DRUG REBATE PROGRAM

DRUG MANUFACTURERS ARE NOW REQUIRED TO ENTER INTO REBATE AGREEMENTS WITH THE FEDERAL GOVERNMENT IN ORDER FOR STATES TO RECEIVE FUNDING FOR DRUGS DISPENSED TO MEDICAID RECIPIENTS. THE PURPOSE OF THE LEGISLATION AS ENACTED IN OBRA' 90 WAS TO REDUCE THE AMOUNTS STATES PAY FOR DRUGS THROUGH A REBATE FORMULA BASED IN PART ON DRUG MANUFACTURES' "BEST PRICE."

OUR SURVEY WORK TO DATE INDICATES THAT DRUG MANUFACTURERS HAVE INCREASED THEIR BEST PRICES FOR PRESCRIPTION DRUGS SOLD TO BULK BUYERS, THEREBY NULLIFYING PART OF THE REBATE PROVISION. THIS INCREASE WILL RESULT IN MEDICAID NOT REALIZING THE FULL ESTIMATED SAVINGS ANTICIPATED OVER THE 5-YEAR BUDGET CYCLE. IT WILL ALSO LIKELY CAUSE DRUG EXPENDITURES TO INCREASE NOT ONLY FOR OTHER GOVERNMENT PROGRAMS BUT THE PRIVATE SECTOR AS WELL.

CONCLUSION

AS YOU CAN SEE FROM THE PREVIOUS DISCUSSION, MANY OPTIONS EXIST FOR IMPROVING THE ECONOMY, EFFICIENCY, AND EFFECTIVENESS OF THE MEDICARE PROGRAM AND FOR CURTAILING FRAUD AND ABUSE. POLICY MAKERS IN THE CONGRESS AND THE ADMINISTRATION ARE FACING MANY TOUGH CHOICES TO MAKE OUR HEALTH CARE SYSTEM MORE AFFORDABLE AND ACCESSIBLE AND TO ENSURE QUALITY OF CARE. WE HOPE THAT THE OPTIONS OUTLINED IN THIS TESTIMONY WILL AID THESE DELIBERATIONS.

MR. CHAIRMAN, THANK YOU FOR THIS OPPORTUNITY TO TESTIFY BEFORE YOU TODAY. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THE SUBCOMMITTEE MAY HAVE.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. I don't have any questions.

Chairman STARK. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me follow up on your last comment on durable medical equipment. I notice in your prepared statement, you talk about two practices. First, you have dealt with the carrier shopping issue. There is a recommendation that bills be submitted to the carrier with this jurisdiction over the residence of the beneficiary. This is incorporated in the legislation that I introduced that I think would go a long way toward rectifying that particular problem that you have pointed out and that the industry has pointed out.

The second issue, though, that you specially highlighted, I am a little bit more confused about, and perhaps you can help me, about high-pressure marketing.

You talk about the fact that there are some unscrupulous dealers that advertise that you can get equipment in your home for no charge. If I understand that, that is illegal today, is it not?

Mr. KUSSEROW. It is illegal, but you still have the ability to do that because the requirements for reimbursement for durable equipment and supplies is that the product that is being supplied is, in fact, a medical product, and to be used for medical purposes and cannot be used for other purposes.

The difficulty you have on that is, people are able to disguise the product and it really is not strictly medical, although it is purported to be. One of the better examples was raised by Mr. McGrath earlier, and that is in the area of transcutaneous electronic nerve stimulators, or TENS units, which apply electrical impulses, and relieve a patient of certain pains; but for most patients, it does not have that kind of effect.

What you might have is a situation where somebody directly contacts the patient and gets the patient to say they want it. They then turn around and put pressure on the doctor.

Mr. CARDIN. But that would be illegal also?

Mr. KUSSEROW. Yes. I hope the specific case has already resulted in a prosecution.

Mr. CARDIN. I guess my point is, it seems to me if you have a supplier advertising free equipment and that—which amounts to a kickback, which I understand is improper—that that should be a somewhat easy matter for you to investigate and deal with.

Is there a problem with the resources that you have in following through on some of these particular matters if, in fact, the circumstances are as you report in your written testimony, that their advertisements for television, radio— it seems like they are making your case for you.

Mr. KUSSEROW. They are if, in fact, they do it in a way that is clearly identifiable. Unfortunately, we never underestimate the genius of the American free enterprise system. People have a way of sending the message without actually saying the words that would get them into specific trouble.

They disguise to the degree possible what is actually going on, yet still convey the message. The other side of it, the other part of your question, though is that, yes, we get thousands upon thousands of complaints, and we have to try to set priorities as to which

ones we can go against, because we do, in fact, have very limited resources to address this kind of problem.

So the answer to both questions is, in the first part, they disguise it; it makes it harder to investigate, although on the face of it, they are prosecutable. And second, that there is a resource problem.

Mr. CARDIN. Another aspect of the legislation that I have filed would call for certification of DME suppliers. Would that not help you in that, if there was that extra leverage of certification or decertification in regards to certain practices of DME suppliers that are unscrupulous and trying to run on the fringes, would that help in your efforts to try to rid out those types of supplier?

Mr. KUSSEROW. Yes, I think all the points you raised that are in your bill would go a long way to control this kind of a problem.

Mr. CARDIN. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. Mr. Kusserow, welcome.

We spend $4 billion a year in direct and indirect medical education subsidy for hospitals, teaching hospitals. In your opinion, who is the beneficiary of that subsidy? Is it the Medicare beneficiary, the hospital and/or the physician?

Mr. KUSSEROW. I followed with enormous interest your line of inquiry with Mr. Bowsher on this subject. I shared all the conclusions that you basically worked to with him, and that is that it is hard to see where the benefit is to the Medicare program, yet the Medicare program is subsidizing this effect.

I will go back to the GAO testimony where it said that the indirect medical education component was introduced back with the advent of the Medicare program; and I don't know what other word to use for it, but I guess coming from an investigative background, I am going to borrow a term and say it is a "plug number," that nobody really quite knew what the effect of Medicare was going to be in this particular arena. But they thought it would somehow disadvantage hospitals, and they wanted to guard against those teaching hospitals; and they developed a very complicated formula.

It turns out that, as we look back, we still can't see the rationale for the indirect medical education component. The one thing we can document is that the IME adjustment factor is too high.

Since the advent of prospective payment, the profits of hospitals or the excess revenue over expenditures has been diminishing, but it appears like it is not going down as much in the aggregate because you do have this one additional area where Medicare is subsidizing teaching hospitals.

The problem with teaching hospitals is that it invokes a notion that it is a hospital right next to a university where you have physicians coming across a street and getting their medical education at this particular hospital, and somehow that is what we are investing in. But yet over half the money in indirect medical education expenditures is at what they call nonsignificant teaching hospitals. These are the ones that are not affiliated with medical schools; these are the ones that are in Blackburg, VA., where they have one or two residents or interns, and somehow, then, they call themselves a teaching hospital and receive subsidy.

And so there is plenty of room, in our judgment, and we have documented this year after year with reports. And I think Congress has agreed, as they brought down the indirect medical education component, that it is too high, far too high.

Your question is, do we need it at all; and it goes back to that rhetorical question, what is it, and nobody seems to know. You asked that question of GAO, and you didn't get what I would consider a satisfactory answer. The fact of the matter is, there is no satisfactory answer. Nobody really knows what "indirect medical education component" means.

Mr. DONNELLY. It was my understanding, back in 1965 there was a concern that we really needed to prop up the health care delivery system in this country, and we needed more physicians, we needed better hospitals. That is why we put the capital program into effect.

I think in 1990 it is a good time to look back and say, are all those direct subsidies good public—necessary public policy today? Wouldn't it make more sense to simply just reimburse each and every hospital, per patient, on a fair reimbursement level, rather than using all of these overlays of subsidies for public policy reasons that aren't really necessary today?

I mean, capital is a classic example. We have very low occupancy rates in hospitals across the country, but we still have a capital program that reimburses them for expansion and renovation. Maybe it all ought to be folded into one direct payment per case.

Mr. KUSSEROW. Your historical analysis is quite right. As we have gone back and looked at the program, we could see that it was the uncertainty of Medicare and what effect it would have on the medical industry, particularly on hospitals, that led to having this indirect medical education component. It was an insurance policy against harm to the institutions that are relied upon.

The fact of the matter now is that it has succeeded. But it may have succeeded too well, that there has been almost a windfall falling to these particular hospitals.

Now, as to whether teaching hospitals—the significant ones that are associated with medical universities—have a more complicated case mix as a result of the fact that they have that higher level of expertise placed at the disposal of patients and, therefore, should get some benefit, could be better answered with a direct medical education component than the indirect medical education component.

Mr. DONNELLY. My time has expired. I have additional questions. I will get back to it.

Chairman STARK. Mr. Chandler.

Mr. CHANDLER. No, thank you.

Chairman STARK. Mr. McGrath.

Mr. MCGRATH. Thank you, Mr. Chairman. Thank you, Mr. Kusserow.

I think we all understand that IME is a proxy payment to hospitals that have teaching components, have sicker patients, and are usually in areas that are somewhat distressed. Until we find a better way of reimbursing those hospitals for their costs, we are pretty well stuck with what we have with IME.

Let me, if I might, go to another question. In your testimony you recommend reducing the number of Medicare contractors. I think you mentioned there that we have 82 presently. Is that nationwide we are talking about?

Mr. KUSSEROW. Reducing nationwide the number?

Mr. MCGRATH. Yes.

Mr. KUSSEROW. Yes, I think we have too many. It seems to me we have two choices at this point in time. One is, you could pull out one aspect of the contractors—and let's say that is processing, just the claims processing, which is a data processing thing—and pull that out separately and have the contracted separately. The fact of the matter is that Congress had moved in that direction in the ill-fated Medicare Catastrophic Coverage Act; one part of that legislation had a pharmaceutical prescriptive drug payment component. That is precisely the approach that Congress had agreed to and HCFA had agreed to, that they could use three contractors who could, in fact, handle hundreds of millions of bills around the country with the exact same standard of payment, the exact same criteria for clearance.

And so one possible reform could be to pull out claims processing and at least have the benefit of 1990 technology to ensure that there is no differential in the country as to how payments are made.

The alternative to that, of course, is to continue funding all 82 different contractors and the systems that support their operations. And you could begin to move in the same direction if you were to reduce the number.

The big problem has been—historically, for the Health Care Financing Administration is that, fine, people might agree you could reduce the number of contractors, just make sure it is not my State. That has been a kind of stumbling block.

Mr. MCGRATH. Let me suggest to you that in my State, I am not sure whether we have too many or too few. I do know that the left hand doesn't seem to know what the right hand is doing in terms of what the regulations are and what they mean. There seems to be arbitrary denials of claims without any notice to either providers or beneficiaries. Unless we get a handle on that, any recommendation to cut the administrative costs by reducing the number of contractors won't mean a hill of beans.

We have to have intermediaries that know exactly what HCFA is talking about. We have to have providers who know exactly what the intermediaries are talking about in terms of regulations. Otherwise, nobody is going to know what is going on, and we will never solve this problem, which has been called the "hassle factor" by physicians and other providers around the country.

It just seems to me we are spitting paper back and forth at each other with nobody really recognizing what each other means. Until there is adequate communication, I think we are going to have a lot of big problems in terms of the administration of these programs.

Mr. KUSSEROW. I agree with that. I think you are quite right.

A part of it is the philosophical legacy of what Medicare is all about, and that is we would not interfere with medicine in the United States, and so we would be nondirective in the Medicare

program. Of course, that conflicts with the desire for standardization.

This has led to the observation by many that HCFA appears to the outside world including the contractors and the providers of services, as being schizophrenic. They speak with forked tongues; you can't seem to get a straight answer.

Part of it is the conflicting nature. They are supposed to be a regulator, but at the same time they are not supposed to be a regulator in the philosophy of what Medicare was supposed to be about.

Mr. McGRATH. Could you comment, in my last couple of minutes here, about the prospective capital reimbursement methodology that is being proposed by HCFA at the present time?

Mr. KUSSEROW. Well, I don't know how far I can go into it. I can go back and say that from the very advent of prospective payment, our office had supported that capital should be part of the prospective payment system, it should be rolled in. The quicker you do it, the better, because, once again, when you have all these different reimbursement systems operating, some of them are prospective in basis, and a few retrospective, it creates all kinds of problems.

We have issued a report documenting the deficiencies in the current reimbursement system for capital. A phasing in process is necessary to permit hospitals to adjust to the changing conditions. HCFA is currently reviewing their notice of proposed rulemaking to fold capital into the PPS system.

Mr. McGRATH. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

As you may remember, we have been talking with you about several problems relating to potential fraud and abuse, the inducements to beneficiaries and the inducements to employees.

Some of these came up as a result of stories about the practices of a small number of cataract surgeons—a small number, but—who were doing a huge volume and were using practices that we thought needed further scrutiny—transportation en masse, for example; one or several had vans that went around to pick up potential patients. Also the issue of paying employees depending on the number of prospective patients they were able to stimulate.

You wrote us back expeditiously about the application of antikickback statutes and that they weren't being enforced for a variety of reasons. Do you have any further thoughts on this, as we look at prospective legislation that would get at, not the kinds of practices that are beneficial to the patient, but really are inducements to them or to the employees? Do you have any further thoughts as to how we proceed to weed out the bad practices?

Mr. KUSSEROW. You are quite right. We have been struggling with this over the past few years, and in fact, since we first began discussing these problems, we have watched a new phenomenon develop, where there has been a tremendous shifting of physicians' interest from directly related services to ancillary services and we are trying to understand what that means.

Why is it that suddenly we find that physicians are opening up pharmacies in their own offices or opening up their own medical laboratories or investing in medical laboratories or in imaging equipment; and what does all this mean? These are phenomena

that are growing so rapidly we have trouble understanding what the effect is.

We have done some studies, some at the request of this subcommittee, to try to understand what effect this has on utilization of services. We are finding that there is increased utilization that is improper as a result of these incentives. And part of these incentives have come from a change in public policy to put the squeeze on.

The one thing we have concluded as we look at the kickback area is that there has been an increased utilization of certain services.

In the case of the cataract example that you gave, where you hear a tale about a van going by a nursing home, picking up a bunch of beneficiaries, then taking them in for cataract surgery, is disturbing. Then we come in after the fact to find out whether those surgeries were appropriate, and we bring a team of ophthalmologists with us, and we find there is no way you can review the medical record to adequately determine whether or not there were inappropriate surgeries arising from this practice. It is very suspicious, but it is hard to make, because, in fact, it comes down to medical judgment, and the medical record does not help you after the fact.

Now, if you stopped the van and you diagnosed the patients before they got to the surgeon, to the ophthalmologist, you might find a lot of those people didn't need that cataract surgery and interocular lens implant.

But it is a very, very tough area. It is really tough because Americans have great faith in their physicians, and when their physician suggests something, the patient responds to that. And I think the challenge for all of us is to make sure that we don't introduce perverse incentives in the system that will act as a barrier between physician and their patient, as to what is best for the patient.

I went around a long way on that, Mr. Levin. I am sorry. But it is a complicated area, and it is one where I wish I had more answers for you than I do and in more clear terms.

Mr. LEVIN. Well, I think we need to seriously discuss the whole issue of solicitation, because, as we put ceilings on expenditures, if we don't find a way to weed out the bad practices from the good, what we are going to do is to help the physician, the minority, the small minority that are abusing the process while we punish, in essence, ethical conduct by the vast majority of physicians.

I mean, that is going to be an outcome of a cap, without looking harder at practices that may be special and perhaps should be abolished.

Thank you.

Mr. KUSSEROW. I agree wholeheartedly.

Mr. LEVIN. I hope we can move legislatively, and we need your input.

Mr. KUSSEROW. We have a whole series of studies, many that are self-initiated, but many are requested by Congress or the administration to try to understand what are the dynamics in the practice of medicine in the United States as a result of recent changes in public policy. And I will assure you that as each report comes up, we will make sure that you and the members of the subcommittee get those reports.

We have a number of them that we are doing in the area of outpatient surgery. We are analyzing what is occurring in the clinics, what is occurring in ambulatory surgical centers, and what is occurring in individual practitioners' offices in the area of surgery. There is a dynamic that is going on there that I know if you are aware of. And yet we have very little understanding as to why that is the case or what is occurring there.

Chairman STARK. Mr. Donnelly.

Mr. DONNELLY. It is always good to have the inspector general up, most especially in these times when we have these lofty talks about embarking on national health insurance and covering all Americans. I think you are a dose of reality. We have a very difficult time running a program for 33 million Americans let alone embarking on covering 250 million.

We will let the indirect medical education costs go because you and I obviously agree. Let's turn to DME. Can you explain in plain English how this scam of forum shopping works?

Mr. KUSSEROW. Basically, controls that exist among the carriers are different and the method of payments is different and the local practices are different.

You can have a situation where the prevailing rate is varying in the country. Also you may have variations in contractor internal controls, especially on new devices that come out with the fancy names and yet are not readily understandable. This can lead DME suppliers to forum shop among the contractors and submit bills anywhere in the country. If they want to run all their bills through Podunk, they put the straw man in Podunk and submit all bills through there and get the maximum reimbursement.

They may get reimbursement like they would not have got anywhere else in the country, but because of this, they will slip them through.

Mr. DONNELLY. You are dealing with 58 carriers?

Mr. KUSSEROW. That is correct.

Mr. DONNELLY. So one for each State plus the Commonwealths and whatever remnants of the old empire are left, basically—Guam has one.

In Massachusetts, a beneficiary rents a hospital bed, and the supplier bills the carrier in California, for example. Because why? The reimbursement in California is greater than in Massachusetts?

Mr. KUSSEROW. Well, they may not have a good control on that particular product, and the fact is that they may permit billings for that particular product as a medical device, whereas Massachusetts may determine that it doesn't meet the criteria of a billable medical device.

Mr. DONNELLY. Doesn't it go to what the reimbursement rate is?

Mr. KUSSEROW. Yes, but the coverage guidelines also play a role.

For example, you may get a billing approved in another State that would not be approved in Massachusetts.

Mr. DONNELLY. How do they do this? Is there a central clearinghouse I can call, an 800 number?

Mr. KUSSEROW. These people are very good on scouting it out on their own. They don't need any help.

Mr. MOREY. The fee schedule is based on ordinary changes that have occurred. The State of Massachusetts may have a high rate or

a low rate; it depends on the historical changes before the fee schedules were developed.

In the past, if they paid the higher rates, then the fee schedule is higher.

Mr. DONNELLY. Is it your opinion that HCFA has the regulatory authority to issue rules and regulations to prevent this source of abuse?

Mr. KUSSEROW. That is my contention.

Mr. DONNELLY. Can you explain how the scam of bundling works?

Mr. KUSSEROW. You can take a device and split it into pieces and then bill for each piece separately, rather than the device assembled.

Mr. DONNELLY. So the device could be reimbursed for, say, $100 for the device, and you break it down into three pieces and bill more?

Mr. KUSSEROW. The bag used for colostomy, you can break that apart and have the ring separate from the bag and bill it separately.

A lot of carriers will not permit that, but if you find a weak link in the system, you can charge it that way.

Mr. DONNELLY. It is part of the reason that we have 58 carriers.

Mr. KUSSEROW. That is part of the problem.

Mr. DONNELLY. Just for the record, it is your contention that HCFA has the authority to promulgate rules and regulations to stop this sort of activity?

Mr. KUSSEROW. To really sharply curb this.

Mr. DONNELLY. I would agree. It is my understanding that they are going to promulgate rules and regulations both on bundling and forum shopping.

Mr. KUSSEROW. I hope it is not just a check-in-the-mail type of thing. I have been around 10 years as inspector general. When it comes from HCFA, I will believe it when I see it.

Mr. DONNELLY. I have met with the administrators, and they have assured me that they will. As soon as they do, we will be giving you folks a call to get your opinion on them. You cannot pick up the newspapers today without reading about some sort of scam going on in the Medicare program. How many criminal prosecutions were there in this area in this year?

Mr. KUSSEROW. In this area?

Mr. DONNELLY. In the whole system.

Mr. KUSSEROW. In our office, we had 155 criminal convictions and many others in the administrative and civil arena. In addition to that, you could have had other possible prosecutions. I would say you could probably add a small handful, just under 15 maybe, that would come from other Federal investigative agencies, like postal inspectors or the FBI.

Mr. DONNELLY. But you handle both?

Mr. KUSSEROW. Most are joint investigations with our office in the areas of our Department.

Mr. DONNELLY. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. In your work with medical equipment, have you focused on the appropriateness of some of the equipment that insti-

tutions send home with recovering Medicare patients, to hospitals, and to convalescent homes?

Mr. KUSSEROW. Yes, we have looked at that.

Mrs. JOHNSON. How does the Government control that? It seems to me that is an area of inappropriate expenditures. I have never quite understood how what we are doing to try to control reimbursements from companies that provide durable medical equipment prevents institutions from overproviding durable medical equipment to patients who are returning home.

Mr. KUSSEROW. That may be so, but again——

Mrs. JOHNSON. If we could simply ban institutions from doing that——

Mr. KUSSEROW. There are some products that really should accompany a patient home. If you had an incontinent patient and you had a plastic urinal container sent with him, that would be appropriate. It doesn't cost very much, and yet you don't want them making the trip without it.

If you have a very expensive device and it has nothing to do with inpatient costs, it should not be considered as such. It should be billed as an outpatient cost and measured as to appropriateness on that basis.

Mrs. JOHNSON. I am thinking of more routine things like walkers, wheelchairs, things to get in and out of bathtubs.

Mr. KUSSEROW. Those are home services. They should be billed separately, not as part of the inpatient cost of somebody at the hospital. If they have had a wheelchair in the hospital, the hospital should not give them the wheelchair to take home. That is separate billing, to have those kinds of supplies provided to an outpatient in the home.

Mrs. JOHNSON. In the area of service reimbursement, have you looked at physical therapy?

Mr. KUSSEROW. Yes, we have. It has probably been about 4 years since we have looked at physical therapy, but we have looked at it.

Mrs. JOHNSON. I think this is another service that has grown as an in-office capability. From the reports I am beginning to hear—and I was not hearing these 4 years ago—there is an awful lot of use of physical therapy that one could question.

Mr. KUSSEROW. If you could let me give you the report that we issued on that subject, I think there is still a lot of relevance associated with it. There are a lot of questions regarding home service and whether qualified people are doing the work or whether you were getting value for services being brought into the home.

We made some recommendations on this subject. I would like to give you an annotated copy of the report.

[Mrs. Johnson received a copy of the report entitled, "Physical Therapy Provided to Skilled Nursing Facility Inpatients," April 1987, Report No. OAI-05-85-00005. Also, a copy will be retained in the committee files.]

Mrs. JOHNSON. Thank you.

There is another aspect of your work that confounds me and that doesn't seem to be able to solve the problem of third-party payers. I still get complaints from retirees that Medicare did not collect from their insurer whom they have been paying for many years. It makes them angry to see Medicare pay when they feel their carrier should be paying.

Why are regulations not tight on that?

Mr. KUSSEROW. The GAO and our office had come out with reports, both inpatient and outpatient in hospitals, whether Medicare is being properly credited for payments. The frustrating thing for me, Mrs. Johnson, is that even when the hospital has a hot check in their hand they wanted to give Medicare, there is no system by which Medicare can accept the check.

They have not been clear as far as the obligation on hospitals to report that, once they did have a mechanism by which they can make payment. HCFA is moving to change that, saying if somebody comes up with a check, they are going to accept it, which is a step in the right direction.

I would like to see a better method by which to set criteria under which circumstances Medicare should be reimbursed. We just don't have those rules now.

Mrs. JOHNSON. On Saturday I am meeting with a group of providers in my district who have had a really terrible time trying to get reimbursement from the Government. They are trying to get consistent, rational explanations and to get reimbursement actions to reflect the explanations they are given.

If we have any hope that single payer offers salvation for America, we ought to try to program and simplify and steamline Medicare to reduce the cost of our own administrative system. I think that all the things that we are talking about here today touch on our inability to make really clean, consistent determinations—admittedly, a complex area of purchase. I mean, medical care is not easy to purchase or easy to define, particularly its appropriateness; but the reimbursement issues are really a problem.

I appreciate the specificity of your recommendations.

Mr. KUSSEROW. In reacting to your last point, you might be able to understand where Connecticut and California, under the Medicaid program, might have differences that could account for differences in how payments are made.

I think what is really frustrating is that we cannot figure out how we can take a federally funded, federally administered program like Medicare and have it the same whether you are in Connecticut, California, Michigan, or wherever. Payment should be made for the same service on the same basis in the same timeliness.

Maybe in the horse-and-buggy days, you could justify differences. But in this day, with the technology that we have, I cannot understand why a doctor in both those States, 3,000 miles apart, should not get similar payments within a certain number of days after submitting the bill.

Mrs. JOHNSON. I agree with my colleague from New York that I am not willing to reduce the number of contractors to achieve that goal until I can have greater confidence that the system will allow us to achieve that goal. I would at least prefer to deal with the devil I know, who is closer to me and who I have some chance of rationally communicating with, than with a system that is still so fraught with definitional problems. It is really inadequate.

But I think the fact that we have such a poor system in Medicare and such a complex one is really a challenge to us. If we think ad-

ministrative costs are an issue, we should try to clean up our course.

Mr. KUSSEROW. I did submit the other idea ahead of the idea of reducing contractors, that is, the notion of pulling out maybe just the processing part, the computer part, and leaving the postpayment and prepayment reviews and other services provided by the contractors and leave that in place. That may be a better avenue to explore.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Mr. Kusserow, I was interested in your recommendation to discontinue the disproportionate-share adjustment. I wonder if you could just elaborate a little bit on what the conclusions you made to come to that recommendation.

Mr. KUSSEROW. When it was instituted, its purpose was to go after hospitals that had a disproportionate share of cases where there was not somebody to pay the bill and, therefore, to try to help those hospitals, rather than have them be disadvantaged. The fear was that you could bankrupt hospitals providing community services that were not compensated.

So it was the uncompensated care problem. Designing it was done on short notice.

I am suggesting that we missed the mark; that is, that you probably did not achieve what you originally intended, and that was to help the hospitals dealing with uncompensated care problems. We have found that the hospitals getting disproportionate share are doing quite well and far better than other hospitals.

I think it is a targeting problem. I don't think you hit the target, so I am suggesting that you revisit that issue, because you are having windfalls go to hospitals that are not the ones you originally hoped to help.

Mr. COYNE. Then maybe a recommendation would not be to eliminate it, but maybe adjust the formula.

Mr. KUSSEROW. Whenever you have the formula problems, it makes it hard, because one of the problems you have is like the one with indirect medical education. You will see the same thing with relative value scales; there will be a lot of problems associated with it.

I would be pleased to meet with you and your staff, if you would like, to go into more detail as to what the problems with disproportionate share payments. Rather than try to tell you how to solve the problem, I will give you the findings and let you draw the conclusion on whether it should be adjusted or scrapped and a new approach taken.

We will be happy to work with you on that.

Mr. COYNE. I would like to work with you on that.

Chairman STARK. I will ask you the same question I asked the Comptroller General. Could you rank for us one or two or three of the most critical areas that do harm to beneficiaries and would take precedence over anything. Let's assume that is dealt with in other areas; then I would suspect it is the greatest dollar leak.

What would you say?

Mr. KUSSEROW. In our report which we have given to the committee today, what we try to do in terms of helping with that analysis is to look at the issue two ways. One is how you close loopholes that would have the effect of raising revenue for the Medicare program. The other side is to look at areas where we have been able, through our audits, inspections, and evaluations, to determine that there is inappropriate leakage from the program.

At the top, I would put the indirect medical education payments problem as worthy of examination, because of the fact that there is so much evidence in that area over the last 10 years.

Chairman STARK. Is that the kind of problem that I am hearing about at Howard University, where the university has overbilled Medicare because of a difference in bookkeeping. Now there are huge amounts owed back to Medicare by universities such as Howard.

Mr. KUSSEROW. That is part of the problem. That is really the smallest part. Yes, the very complicated formulation that determines what you pay, allows for fumbling around and lots of potential for error or waste.

The more fundamental problem that we have monitored closely is the effect of indirect medical education. We think the findings are compelling and that the IME payment can be adjusted very dramatically. I have not made a recommendation that it be eliminated.

That is not to say it should stop you. I cannot make policy or profess policy. All I can tell you is that, based upon the work that we have done, it warrants a reexamination, because there is a windfall that is going to many of these hospitals that I don't see was originally intended by the Congress.

I cannot find anywhere in the Congressional Record that what we are seeing today was intended.

Chairman STARK. I have no quarrel with you on that. I would be the last one to sit here and tell you that I don't see disproportionate share and indirect medical education and a host of other adjustments as subsidies to hospitals. But, because we are unable to get HCFA to demand uniform reporting, which would enable us to know precisely how well each of these hospitals is doing, we just don't know. I do not expect that you accurately know either.

Mr. KUSSEROW. I don't even know inaccurately.

Chairman STARK. You would agree with me, that 6,000 hospitals are pretty easy for a computer to keep track of. If hospitals reported income and expenses, we could push a button on our little laptop and get specific information overnight. For whatever reason, the process is much slower.

We adjust. We try to subsidize. There is no question that we subsidize rural hospitals extensively. While it is in our best economic interest to let these institutions go bankrupt, there are obviously political reasons why we cannot. But that does not escape the point that they are inefficient. Many should not be around.

There is, on the other hand, it certainly appears to this committee, a compelling reason, primarily in inner cities serving a huge indigent population, ways to funnel money to those hospitals who have huge uncompensated care and/or charity, if they call it that. But they are just not getting paid because they have a lot of expen-

sive cases with people with no insurance or no money. We know we are doing that; sometimes we are accused of it.

I will stipulate, we are trying to find ways to subsidize certain hospitals. I think that is a valid function. We can argue that here. So if you and I are being very candid with each other and we are trying to subsidize the inner city hospitals, what are the big subsidies that get big support out of the doctors in graduate medical education, which seems to go on in these same inner-city hospitals?

But, if we took away disproportionate share and graduate medical education, how would you suggest we get money into these inner-city hospitals who are providing care to those who are indigent? I will not accept celibacy or abstinence as a response.

Mr. KUSSEROW. I always look at evidence past rather than what should be in the future.

We have the dilemma of an aging hospital infrastructure in this country and a changing set of demographics about who goes to the hospital and how they get there. We are in the process of replacing this aging infrastructure, and the difficulty is, which ones do you replace?

As you concentrate on how to solve the problem in the inner city, then you have the problem of the rurals. As you pointed out, there are many hospitals that are having very severe problems. The reason they have problems is that doctors are not submitting patients there.

If a doctor has a choice of taking somebody with a heart attack and sending them to a 30-bed hospital down the street or one 10 miles down the road with an acute cardiac care center, the doctor will send them where they will get the best treatment.

You are balancing a lot of political balls in the air as you work with the urban hospitals and the uncompensated care, where you are going to get the money to do it.

I am not a policymaker. I cannot answer that question.

Chairman STARK. What I am suggesting to you is that the policies you are recommending are going to take money away from those hospitals. You and I know that. I think you are right. I don't know why we are funding medical education through Medicare. It happened in 1965 or 1967.

I will introduce the bill to get rid of it, but you have to tell me then where do I get the money for these hospitals that I don't want to penalize?

Mr. KUSSEROW. First of all, let me submit that as you break down the numbers at the teaching hospitals they are far better off than the community hospitals or some of the other categories of hospitals that you have. We are not talking about those hospitals that have been badly suffering.

But as far as approaching the problem is concerned, I submit that one way to do that is in the area of teaching hospitals to recognize the fact that there are teaching hospitals which cater to a special population of special problems because they are associated with a medical school and, therefore, others that are categorized as a teaching hospital because they have somebody on residence, therefore, they are a teaching hospital.

One way to look at it is to try to focus on those hospitals which are treating a lot of patients associated with a medical school.

Then you get back to the problem where a lot of those nonsignificant hospitals are located in rural areas and then you have aggravated the problem with the rural area hospitals which have problems getting patients.

The more beds that are left unoccupied, the more they have to look for Uncle Sam's deep pockets to keep them going. The nonteaching hospitals are doing very well. You have denied the nonteaching hospitals the benefits given the teaching hospitals. Most of them are not dealing with uncompensated care problems in the urban centers.

Chairman STARK. You have heard discussion here today about all payer and single payer. Maryland operates under a system like that, at our sufferance. I gather you don't, therefore, investigate Maryland hospitals for fraud and abuse. Maybe you do. But if you don't, are you aware of how well they are meeting their obligations? I gather we give them a waiver because they spend less than we would otherwise spend under Medicare. How are they doing?

Mr. KUSSEROW. I don't know, but I do have a right to go look at them. If that is a desire of the subcommittee, I will go look at them.

Chairman STARK. My question is, under that system, is there any more or less fraud and abuse in an all-payer system administered by the State of Maryland? It has to be less than Florida. You and I can agree to that.

How do they compare with Wisconsin or Pennsylvania? It might be interesting to see whether or not when you have a single rate or all payers just relative to hospitals, whether there is less chance to game the system. Maybe that is a question I ought to ask GAO. I didn't know whether you had to survey what they were doing to prevent fraud and abuse.

Mr. KUSSEROW. If you and this subcommittee find it interesting, we will come back with the answer to it. We will look at it.

Chairman STARK. Is it correct that a fraud and abuse investigation would be the responsibility of the State of Maryland?

Mr. KUSSEROW. I have concurrent jurisdiction with the State of Maryland on the Medicaid program.

Chairman STARK. How about Medicare?

Mr. KUSSEROW. I have a right to oversee the Federal interest in the Medicare program. Between the two, I have no problems looking at those. We certainly can do it.

The thing I think is going to be a real challenge to policymakers as they look for an all-payer system is how do you integrate all the different systems that we have. We are 50 sovereign States formed into one union and God loves us for trying to work it out.

Chairman STARK. One payer.

Mr. KUSSEROW. The challenge of getting there is really going to be interesting to watch, how you overcome that.

Chairman STARK. I agree with you there.

Let me ask you one more question. I am going to make an assumption here, but there are several areas where HCFA just has not come up with the rules to implement provisions that the Congress has enacted. For instance, in OBRA 1990, there was a provision to require physician services to complete certificates of medical necessity for DME claims and, second, payer plans have been

ineffective. Now, there are two alternatives that occur to me. You may not be able to respond to these because you may be the wrong person to ask. But it occurs to me that there is inadequate funding or that streamlining the system within HCFA, that they have just streamlined themselves down to a point where there is a lack of staff and resources to implement our proposals. It has occurred to us from time to time that maybe people in the Department or OMB just don't want the rules to be developed quickly because they don't like them. That does not surprise me and I am not trying to be indignant.

If you have these choices, does HCFA need more resources to get the rules and regulations out so that the providers know what to do? Do we have to argue with somebody else in the administration? Is it a question of saying if the will was there, the ways and means exist within your operation or is there some third item?

Mr. KUSSEROW. I think it is all of the above.

The kind of action that you need to take, especially the really complex areas of regulatory actions that are necessary in Medicare to bring them through the system, you are talking about very specialized talent. You are talking about people who are highly skilled, highly trained and understand the effects.

Part of the problem is that, yes, you do not have a sufficient number of that high talented sort of person to write it. Part of the problem is the people writing the regulations in the health care arena are the same people over and over again, and you know how hard they are working.

Part of the problem is the requirements based upon the department on how many can the system operate with. Sometimes you have differences in political philosophy between what the executive branch and what the Congress wants to do. Sometimes the regulatory arena is a place where that gets expressed in clear terms or unclear terms. It is not an overall resource problem.

Chairman STARK. My final question——

Mr. KUSSEROW. If I may interrupt the Chairman, we mentioned CLIA earlier on. I testified for 3 years that CLIA should not have gone to the agency. HCFA is a reluctant regulator. Most of the labs that are going to be affected by CLIA are not services to be provided our beneficiaries.

I think one of the reasons they were slow in getting started is because they did not have the same motivation. I think sometimes where you put the priority depends on how you feel about the issue.

It doesn't have to be big "P" politics. It can be small "p" politics.

Chairman STARK. Very interesting. I think we agree that all our jobs would be simplified if we had a uniform reporting system and uniform data basis we could handle in terms of reimbursement. Is that a fair statement?

Mr. KUSSEROW. It is, but that is not the whole problem.

Chairman STARK. I understand that, but there are a multiplicity of both computer programs and ways of reporting.

Mr. KUSSEROW. You are always ahead of the game.

Chairman STARK. We are now undertaking a change in the accounting systems that the providers are supposed to use and we are mandating that there be eight different systems created by eight

different data processing mavens. So California, Texas, Alabama, Florida, and somebody like New York are going to have one system. They went out and got another contractor with no mandate that the contractors use the same kind of data base, same kind of software or programming language. Does that make any sense to you?

Mr. KUSSEROW. When you speak to the auditor for the Department and talk about accounting systems, you will not have anybody in my shoes excited about a multiplicity of systems. I would prefer to have one single accounting system.

Chairman STARK. What is the reason for it?

Mr. KUSSEROW. They talk about the regional differences and the variables.

Chairman STARK. Whoa. I can understand that you might feel we get too much sun in California and it affects our heads. Maybe you ought to put us all in one box. But Florida, New York, Alabama, there was no reason; it is almost like a random walk to put these eight groups together. Why are we doing that?

Mr. KUSSEROW. I cannot speak on that point. If it was assigned to me and if I had the power it would not go in that direction.

Chairman STARK. If you had the power and I can share it, wouldn't it be better to say I will take eight States and try it and see how it works. If it works, then fine, let's add other States to an identical system. But to purposely mandate that there be eight different systems——

Mr. KUSSEROW. I think the idea is that if you are reducing the number of different systems, my approach would be that it would be nice if we could develop common fields of agreement and try to standardize that nationwide, but I am not the one who is directing that.

Chairman STARK. But you are the guy who will have to go out and discover fraud and abuse within these systems. I would like to try to simplify your job.

Mr. KUSSEROW. I wish we had a single accounting system. I wish we had a single electronic data processing system or a single set of rules under which we pay Medicare so we don't have the differences we have now.

It seems to me a beneficiary in California or a beneficiary in Virginia is entitled to the same quality of health care and entitled to the same services and that the physicians and other providers are entitled to make payment on the same basis. I have trouble with the differences that currently exist.

Chairman STARK. We do, too.

Thank you very much.

Mr. DONNELLY. Just one last question, if I could, in your opinion is there any justification for the Medicare program subsidizing hospitals whether it be through capital subsidy or indirect or direct medical education, subsidizing hospitals that refuse on the other hand to sign a Medicaid provider agreement?

Mr. KUSSEROW. Speaking as the inspector general and representing the taxpayers' interest, whenever you divert Medicare expenditures for anything other than caring for our beneficiaries, I am bothered by that. But it is not my business to decide how Medicare dollars should be expended.

Policymakers can do that. But I am always bothered when you try to use Medicare to do things Medicare was not designed to do because it takes away from its core, especially when you look down the road and see that it is going off the cliff here by 2015. So we know we are about to run out of money. I think we have to be careful how we husband those resources.

Mr. DONNELLY. That is a good answer, but it is not an answer to my question.

My question directly is, we have a series of subsidies in the Medicare program that have been there since 1965, education reimbursement, capital reimbursement, et cetera, things that in my opinion should be folded into the prospective payment rate.

On the other hand, we run another Federal program for the poor people in America. That is called the Medicaid program. So you have a nonprofit institution accepting the goodies from the Medicare program on the one hand, but refusing to treat Medicaid patients which is the left hand of the Federal program. There are two Federal programs. We are the Federal Government. We have to make sure that both the elderly, and you have responsibility over Medicaid oversight, and the poor are treated in a nondiscriminatory fashion.

Mr. KUSSEROW. I agree with you. There are not just two arguments. Hill-Burton is another program in our Department. That is one of the conditions of the grant, that they would, in fact, not turn away people who are unable to pay, including Medicaid patients who are unable to pay. It should not be just Medicaid, but it should be people who do not have coverage.

Mr. DONNELLY. Minimally Medicaid.

Mr. KUSSEROW. Minimally Medicaid.

Mr. DONNELLY. How many provider agreements have been terminated under the antidumping statute?

Mr. KUSSEROW. Very few. I will look it up and tell you later.

[Mr. Kusserow subsequently responded: No provider agreements have been terminated under the antidumping statute.]

Mr. DONNELLY. How many fines have been assessed?

Mr. KUSSEROW. Two.

Mr. DONNELLY. It is my understanding that there was just one cancellation of a provider agreement for a period of about two weeks. Would that be correct?

Mr. KUSSEROW. That is correct. The terminology is that you terminate a hospital. Actually, you take steps to put them on notice, but if they come into compliance during the period of time that they are allowed, that they will not be formally or officially terminated.

Mr. DONNELLY. Is it your belief that the clarifying language in last year's OBRA has helped you?

Mr. KUSSEROW. Yes, sir.

Mr. DONNELLY. So we expect to see either more fines or more people barred from the system because the practice is still going on?

Mr. KUSSEROW. It is going on. We have seen marginal increases. I think that there are still a lot of problems associated with it. I

think I have to do more work on it before I come back here and testify.

Mr. DONNELLY. Thank you.

Chairman STARK. Thank you very much. As always, we appreciate your cooperation and your hard work. It is helpful to the committee.

Mr. KUSSEROW. Thank you, Mr. Chairman.

Chairman STARK. Our next witnesses represent many of the contractors who were charged with fighting fraud, waste and abuse in the fiscal intermediaries of carriers and PROs. We are pleased to welcome Mr. Donald Cohodes, the vice president of the Blue Cross-Blue Shield Association and Dr. David Busby, vice president of the American Medical Peer Review Association.

Gentlemen, you may summarize your statements or expand on them in the order that you were called.

STATEMENT OF DONALD R. COHODES, VICE PRESIDENT, FEDERAL PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. COHODES. Thank you, Mr. Chairman.

I appreciate the opportunity to be here to represent Blue Cross and Blue Shield contractors and to discuss their activities in the Medicare program from the standpoint of inappropriate and unnecessary payment for services.

Before that, I want to express my appreciation to the committee for this opportunity. From what we understand, the decisions of the House Labor and the HHS Appropriations Subcommittee are going to create a continued problem for us in 1992 if their decisions stand. It appears the President's budget for Medicare contractors next year will be upheld by the committee with additional money for the contingency fund. If that should continue in that fashion, we can predict further reduction in services to Medicare beneficiaries in fiscal year 1992.

The impact of the budget will be felt most directly on a couple of areas of, I would imagine, deep concern for this committee, which are payment safeguard activities and beneficiary and provider services.

On payment safeguards, we engage in three major activities: the audit function, medical review, and Medicare secondary payer, which is a coordinator of the secondary function.

In the audit function, we review hospital records and records of other facilities to be sure the information provided is accurate and to prevent wrongful billings from taking place. The audit is the final and most inclusive test to be sure only legitimate costs are paid.

We check for excessive reimbursement, violations of law, mathematical errors and for fraud and abuse. The budget pressures are going to be acutely felt this coming year. If the budget should prevail, we will be reducing the level of effort in this function in 1992.

HCFA has instructed us in preparing our budget to anticipate a 12-percent reduction in desk reviews and an 18-percent reduction in final settlements. Complicating the matter significantly, though, will be the new capital regulations. Those regulations will divert

resources and energy of audit staff away from their normal functions and they will come at a high opportunity cost.

We will be spending considerable time trying to establish the accurate baseline for capital payment and as a result of that, we will not be conducting as many audits, field reviews, or desk assessments of other institutions.

Our medical review function is designed to assure that services rendered to Medicare beneficiaries are necessary, appropriate, and that they are covered. We use both prepayment screens, which are a mechanism to identify services that are medically necessary and postpayment review for profiling to identify aberrant behavior patterns.

Again, money becomes a critical factor here. In 1989, we were reviewing on part A about 12 percent of all claims to determine their medical appropriateness. In 1992, if the budget prevails, we will be reviewing about 3 percent.

In 1989, for part B, we reviewed over 18 percent of claims. In 1992, we anticipate reviewing only 12 percent. This is particularly disturbing in that we know one of the major benefits of the medical review function is the sentinel effect it has on provider behavior.

We are saying to those few in the provider community who might abuse the system that there is little risk of being detected from doing so.

Our third payment safeguard function is the Medicare secondary payer program. Here, we try to assure that the appropriate payer pays first, which is in many instances not Medicare, particularly for the working aged, ESRD beneficiaries and worker comp.

Finally, we spend a good deal of time and energy identifying the fraud and abuse leads that are developed out of all of these activities. One of the prime sources we use to identify problems of fraud and abuse are beneficiaries. Again, the budget for fiscal year 1992 is going to make that source of development very limited. Funding for beneficiary toll-free lines next year has been eliminated so beneficiaries will have an extremely difficult time in getting to us to raise questions about claims, to identify patterns of double or excessive billing, kickbacks or false information, or any of those kinds of things.

So where we stand in the end is that we believe there is much more that we can do to safeguard Medicare trust fund dollars. If funding had been held at a consistent level, we would have been able to save an additional $1.5 billion with the trust fund dollars that have now been lost. We feel that loss will continue for years to come.

We believe the payment safeguard activities the contractors perform are strong functions that save the trust fund billions of dollars. We believe that they should be funded adequately. We hope and look for this committee's support in that regard.

Thank you.

Mr. PEASE [presiding]. Thank you.

[The prepared statement follows:]

Statement of Donald R. Cohodes, Vice President, Federal Programs, Blue Cross and Blue Shield Association

Mr. Chairman and members of the subcommittee, I am Donald R. Cohodes, Vice President of Federal programs for Blue Cross and Blue Shield Association. I appreciate this opportunity to discuss the role of the Blue Cross and Blue Shield Association as the Medicare intermediary and carrier.

As you requested, my statement focuses on our activities to safeguard Medicare from inappropriate or unnecessary payment for services. In particular, I will discuss our audit, medical review, and Medicare secondary payer activities and our efforts to prevent Medicare fraud and abuse. I also want to share with you our continuing concern about the lack of sufficient funding for these important operations.

On the issue of funding, we appreciate the leadership role that this Subcommittee plays in supporting adequate funding for Medicare contractors. We share your concern about the need for sufficient funding for the proper administration of the $120 billion Medicare program. This is a concern that is also shared by many other groups as well whose members rely on Medicare payments being made promptly and accurately.

The Blue Cross and Blue Shield Association and its member Plans have been part of the administration of Medicare since the program's inception in 1966. From the start, the federal government turned to us to help manage Medicare benefit payments. However, in recent years, the benefits provided, claims volume, and the complexities of the program have increased enormously while the willingness of the federal government to provide the resources needed to manage the program has been constricted. As a result, the role of contractors has become more of a bill paying activity and less emphasis has been placed on the management of Medicare benefits. Clearly, this imbalance needs to be addressed if we are to ensure that Medicare dollars are spent properly.

We could be doing much more to manage the program more effectively and to detect and reduce fraud and abuse if the federal government committed the necessary funds to those activities. In our private insurance business, we are aggressive innovators in managed care, medical review, and customer cost containment activities.

Despite the current funding problems, we believe that the partnership between Medicare and its network of contractors has served the program well over the last two decades. Through this network, Medicare has been able to maintain an enviable record of administrative efficiency, particularly considering the program's size and complexity. And, by preventing improper or inappropriate payments, contractors provide close to $4 billion in savings to Medicare each year, more than Medicare's entire administrative budget in fiscal year 1991.

Now, let me discuss our payment safeguard operations more directly.

Medicare contractors have three basic payment safeguard responsibilities. First, there is the audit program which involves reviewing the financial records of hospitals and other health facilities to prevent wrongful billing and to ensure the proper allocation of costs. Second, claims are reviewed to determine if the services provided were medically necessary and appropriate. And third, collections are made from employer group health plans when they are determined to have the primary payment responsibility for health claims and Medicare is the secondary payer.

These operations have consistently achieved impressive savings for the federal budget and the American taxpayer. In fact, few, if any, government expenditures produce such hard, documented savings each year as are generated by Medicare's payment safeguard activities. For FY 1989, the Health Care Financing Administration (HCFA) reported that with a budget of $358 million, Medicare contractors achieved $3.96 billion in benefit savings, a return of over 11 to 1. However, the funding level for these activities was reduced substantially in FY 1990 and has remained frozen in subsequent years, resulting in higher trust fund expenditures due to the reduced activity level.

But the savings themselves are only part of the picture. Ultimately, the goal of the payment safeguards structure is to assure that Medicare funds are spent as intended by Congress for medically necessary and appropriate care and only when the trust funds have an obligation to pay. Moreover, these operations have an essential "sentinel effect" by sending a strong signal that Medicare is serious about being a prudent and vigilant payer for health care services.

It is important to point out that the overwhelming majority of Medicare claims -- nearly 600 million this year -- are submitted for legitimate services by conscientious health care providers and beneficiaries.

However, Medicare is a very complex program involving the payment of $120 billion for services with hundreds of different payment policies, fee schedules, exceptions, adjustments and limits. And for those who may try to take advantage of the system by concealing costs or billing for services for which Medicare should not pay, payment safeguard operations are in place to detect these wrongful practices.

Next, I would like to briefly describe how these payment safeguard operations work.

AUDIT

The Medicare audit function represents the final and most inclusive opportunity for Medicare's fiscal intermediaries to review Part A program expenditures. Reduced to its essence, the audit function involves scrutinizing a health care facility's "final billing" for services to ensure that only legitimate costs are paid and that Medicare is protected from costs which are unreasonable, unnecessary or illegal.

Even after the introduction of the prospective payment system (PPS), there are still significant areas where Medicare payment is based on costs. Further, the audit of provider cost reports is the primary instrument to maintain the integrity of Medicare Part A program payments and the foundation for sound policy decisions on needed payment adjustments.

Basic to the audit program effort is the analytic review of cost reports to determine excessive claims for reimbursement, violations of law or regulation, mathematical errors, and fraud and abuse against the program. When necessary, professional accountants are sent on-site to a hospital or other health care facility to review the provider's financial records. Finally, the auditors develop a final settlement with the provider which determines the total payment due for the services provider to beneficiaries.

Many of these responsibilities closely resemble those of the Internal Revenue Service and, like the IRS, involve many of the same skills and training for the auditors. Medicare payment policy changes frequently with legislation. It is contained in very complex regulations and instructions in the Provider

Reimbursement Manual. The audits are directed at those areas in the cost report which have been determined from a desk review to be the most likely to be misstated and thus result in savings to the program. In total, HCFA expects that these audit efforts will save over $840 million in fiscal year 1991.

Audits will be critical to the smooth transition to blending capital costs into the prospective payment system. It is likely that all PPS hospitals will need to be audited during FY 1992 to establish their hospital specific rates. This activity would come at the expense of virtually all other audit activity. There will be very little, if any, Medicare costs recovered through the capital audits, and Medicare will forego the audit savings from normal audit activity. In fact, the losses to the Medicare trust funds may be exacerbated by the reduction of the "sentinel effect" of normal audit activity.

MEDICAL REVIEW

Medical review activities assure that the services provided to Medicare beneficiaries are medically necessary, appropriate and covered by the program. For example, more than one physician visit per month to a patient in a skilled nursing facility would not be considered medically necessary absent documentation explaining the condition or symptoms warranting the additional visits.

To perform these operations, prepayment review of claims is conducted based on national and local "screens" to flag services that may not be medically necessary. Postpayment audits of claims are also performed to identify patterns of potential over-utilization, fraud, or abuse when compared with peer group norms. In addition, staff in this area educate providers on issues of coverage, billing practices and expected patterns of care. We believe that our provider education efforts are particularly important and help prevent wrongful billing practices prior to submission of a claim.

Let me clear up one of the most frequent misconceptions about the use of computer screens to detect potential problems. The Medicare program requires the use of approximately 20 national screens to identify inappropriate claims. In addition, based on their unique understanding of the provider community in their area and potential problems, carriers establish a series of additional local payment screens. In all cases, the screens are used to determine which claims need to be examined more closely. They do not generate automatic denials. Rather, claims that fail to pass the screens are suspended until a further review determines whether Medicare should pay.

Many contractors' medical review operations are conducted by a team of reviewers including licensed practical nurses and registered nurses who conduct most of the "hands on" review effort. We also have a Medicare medical director, a practicing physician who is responsible for recommending and approving new medical review policies and acting as a liaison with the provider community. In difficult cases where medical necessity or appropriateness are at issue, the medical director also serves as the ultimate arbitrator of our payment decisions.

HCFA expects that these medical review activities will save Medicare $1.1 billion in fiscal year 1991. Even more important than the reported savings however, is the deterrent effect that a vigorous medical review operation has by making it known that Medicare payments will be scrutinized.

MEDICARE SECONDARY PAYER

The third, and final, payment safeguard is the Medicare Secondary Payer (MSP) program. The purpose of this program is to ensure that Medicare payments are not made for services

provided to beneficiaries who have other coverage that is primary to Medicare. We view the MSP program as a coordination of benefits activity which saves the Medicare program money by identifying the primary payer of health benefits.

Among the other payers whose coverage may be primary to Medicare are employer group health plans covering the working aged and spouses, disabled and ESRD patients as well as auto, liability, workers' compensation, and no fault insurance programs. The MSP program is extremely cost efficient, realizing savings of approximately $35 for every dollar invested and accounting for over $2 billion in direct savings annually to the trust funds.

We support efforts to improve the identification and collection of MSP cases. Provisions contained in OBRA 89, that originated in this Subcommittee, will be implemented shortly by HCFA and will provide better information for MSP collection efforts. In addition, the Oversight Subcommittee has recommended further improvements in the MSP program which we believe will strengthen these operations in the future.

PREVENTING FRAUD AND ABUSE

Medicare contractors have important responsibilities in detecting and preventing fraud and abuse. Sometimes these cases are brought to our attention by beneficiaries who inform us when Medicare has been billed for services that they did not receive. More often, our payment safeguard operations lead us to suspect instances of wrongdoing which are then investigated further.

Examples of these types of practices include:
- o double-billings and inflated billings;
- o kickback schemes for making patient referrals or signing false treatment plans;
- o submission of costs for which medicare payment is excluded; and
- o false information about a patient's condition to qualify for benefits.

Many of these cases require months of meticulous review in order to validate the alleged instances of fraud. Guidelines developed by the Inspector General (IG) are used to refer cases for possible disciplinary action, including financial sanctions or suspension of providers from further Medicare payments. After the IG has taken such adverse actions, contractors are required to ensure that no payments are made to the excluded providers according to the terms of the judgment.

IMPORTANCE OF FUNDING

Clearly, we believe that the payment safeguards efforts of Medicare intermediaries and carriers are among the best investments made by the government and are essential to the sound management of its health care dollars.

This assessment is also shared by the independent Physician Payment Review Commission (PPRC) which has consistently called for Congress to provide "stable and adequate funding" to fulfill Medicare contractors' payment safeguard responsibilities. Last year, GAO recommended to the subcommittee that Congress provide more spending for payment safeguard activities citing an $11 to $1 return ratio on the investment.

This subcommittee has consistently supported adequate funding for these activities. We appreciate the subcommittee's efforts to raise these concerns to the attention of the House Labor, HHS, Education and Related Agencies Appropriations Subcommittee before its mark-up of the annual spending bill.

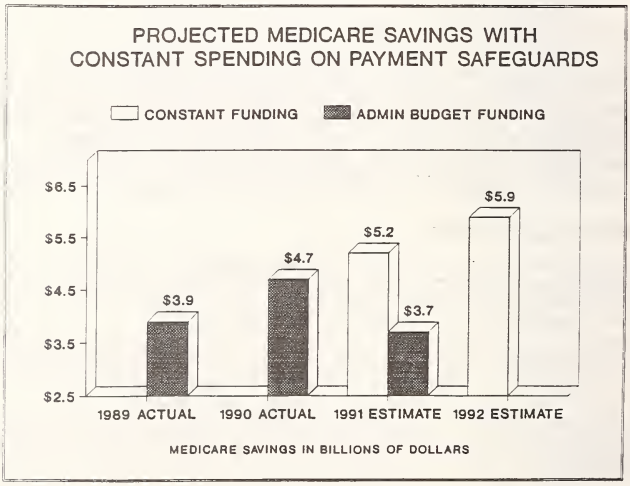
Once again, we remain deeply concerned about the outlook for adequate funding for the FY 1992 operations of Medicare contractors and the prospects for improvements in the payment safeguards program.

Payment safeguard operations were the first activities to be cut when funding for Medicare contractor operations became constrained in FY 1990. Since that time, funds for payment safeguard activities have been frozen even though the number of Medicare claims which should be reviewed has increased by ten percent each year. If spending had kept up with the growth of the Medicare program, payment safeguard activities would be allocated approximately $500 million for FY 1992 as compared to the $333 million in the Administration's FY 1992 budget.

A very direct result of freezing the funding level for payment safeguard activities is a corresponding reduction in the number of claims subject to medical review and audit. Since the volume of medicare claims increases at an annual rate of about ten percent, and the funding level has been frozen, the available funds are used to simply process claims so actual percent of claims reviewed is decreasing. This has resulted in "audit lottery" in which it is less and less likely that erroneous claims will be reviewed.

Additionally, HHS and the PPRC have projected that claims volume will continue to increase by double digit percentages due to physicians submitting additional claims in response to lower reimbursement under the new physician payment reform system, i.e., RBRVS.

As the following graph indicates, Medicare would be saving $5.2 billion in fiscal year 1991 if the payment safeguards budget had been maintained at a funding level consistent with the Medicare program's rate of growth. By curtailing this investment, the Administration is projecting savings of only $3.7 billion, a loss to the program of $1.5 billion this year.



Certainly, additional investments in protecting Medicare from overpayments and improper spending will still yield very positive returns. Even more importantly, you can see why we believe that reductions in the payment safeguards budget make

little sense. Clearly, Medicare ought not to spend an additional $11 for improper benefits to save $1 of administrative cost.

BUDGETARY TREATMENT

We are concerned that the budgetary constraints limiting Congress' ability to provide additional funds for contractors' payment safeguard activities will not lessen in the near future. The budget process creates a disincentive for the President and Congress to appropriate adequate funds for Medicare administration, since the appropriation counts against the domestic discretionary spending caps in the new budget law but the savings to the Medicare trust fund resulting from the activities are not counted.

We would be pleased to work with Congress and the Administration to develop a means to adequately fund the payment safeguard activities and protect the Medicare trust funds. One place to start would be for the budget process to "count" the savings from payment safeguard activities, and not just the costs.

CONCLUSION

In closing, let me assure you that we share your concern about protecting Medicare from fraud, abuse and inappropriate spending. Unchecked Medicare spending has consequences on the federal budget, taxpayers and the program's beneficiaries that far exceed those of dozens of other federal programs.

Adequate, stable and predictable funding for Medicare's payment safeguard operations is a sound investment. We appreciate your continued interest and support for these activities and we look forward to working with you to improve the administration of the Medicare program.

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Mr. PEASE. Dr. Busby?

STATEMENT OF J. DAVID BUSBY, M.D., VICE PRESIDENT, AMERICAN MEDICAL PEER REVIEW ASSOCIATION

Dr. BUSBY. I welcome this opportunity to be with you after being with you last year. We thank you for the help you provided PROs in taking care of some burdensome problems we had.

Last year, one of the things we mentioned was the purpose of the PRO program. The PRO program was set up by Congress and HCFA and the Medicare beneficiary community in response to the potential risks to quality and appropriateness of care arising from incentives of the PPS system for hospital services.

We have documented that such concerns did not materialize. We agree with Chairman Stark's statement that Medicare does a better job of controlling costs than any other plan in the United States. That is particularly true if you look at part A. If you compare admissions from 1983 to 1989, we have gone down 6,000 in admissions to 11,200,000. That is a use rate that drops 431 admissions per 1,000 beneficiaries to 368 per 1,000 beneficiaries.

The important thing to remember about that is that in spite of that change, there has been no perceptible drop off in the quality of care provided. The Rand study has documented that.

While there may be some question of instability at time of discharge largely because the most acute services may not be there, the mortality has not changed and process indicators in the hospital setting have improved.

The costs of inpatient expenditures increased in part A. They have gone up 6.1 percent. If you look at part B, it has increased two to two and a half times that. We believe because of that, that it is time to move away somewhat from the first generation of peer review organization structure and function to a new generation. We agree with the basic strategy that has been laid out saying that we utilize more information that can be fed back to providers and practitioners to help improve the quality of care.

The recommendations that we are making as a trade association representing 43 of the 44 PRO organizations are attached to the report. I would like to point out the most critical points. We think it is time the PROs have flexibility on how to focus review. All of the organizations know where the problem areas are. If they could focus review in their own States, we would be better off. There must be some accountability so that the peer review organization is handling that appropriately.

We believe the uniform clinical data set is an excellent concept. There are two principles for it being developed: consistency of review and epidemiological data base. We are fearful that a premature birth of UCDS may be the death of it. There are seven organizations doing a pilot test of it. It is too soon to place it fully in practice. These pilot projects should be allowed to incubate longer before it is taken to the rest of the Nation.

We are also concerned that something should be done to start looking at review on an ambulatory basis. If you look at the law that requires review beginning on January 1, 1992, we need to look

at some sentinel conditions or look at a targeted review. At this time there is nothing in the works for us to do this.

We would also request that the committee consider clarifying language for the program that might be helpful. One of the bills passed last year ended up with language that was confusing and was not what was intended by the legislation. That is that the PRO notify State medical boards in their State after a sanction notice has been issued and the individual has met with the committee and the committee has confirmed that problem.

We would very much request your help in these areas and hope you would have time to look at the other recommendations made by the American Medical Peer Review Organization.

[The prepared statement follows:]

Statement of J. David Busby, M.D., Vice President,
American Medical Peer Review Association

Mr. Chairman and Members of the Subcommittee, I am J. David Busby, M.D., Vice President of the American Medical Peer Review Association (AMPRA) and Medical Director of the Arkansas Foundation for Medical Care, Inc. (AFMC), the Peer Review Organization (PRO) for the state of Arkansas. On behalf of AMPRA and its members, I am pleased to have the opportunity again this year to present our views regarding needed oversight of the Medicare program and specifically our recommendations for further improvements in the PRO program.

PRO Program: A Brief History

Mr. Chairman before turning to future opportunities for PRO program improvements, I think it important to briefly review the short history of the PRO program. From AMPRA's perspective we are nearing the end of the first generation of PRO review. As I testified before you last year, it must be understood that the design of the PRO program, since its inception, has been a reflection by Congress, the Health Care Financing Administration (HCFA) and the Medicare beneficiary community of concerns regarding the potential risks to quality and appropriateness of care that may arise from the incentives of the Medicare prospective payment system (PPS) for hospital services. PRO review has been specifically tailored to address such PPS concerns as inappropriate admissions, premature discharges, and DRG coding manipulation.

In retrospect, we should not be surprised that PRO objectives were so clearly tied to PPS oversight. While now it might seem strange given its universal acceptance, in 1983 PPS was a largely untested hospital payment system which raised many concerns within the Medicare beneficiary community regarding the impact on patient care. It was inconceivable that Congress would introduce such a radical reform without also unveiling a quality and utilization oversight program.

Viewed from this perspective, the PRO program has met many of the original objectives set for it. Last year in our testimony, Mr. Chairman we presented detailed results of PRO review and the related impact on aggregate inpatient utilization and quality patterns for the Medicare program. Allow me this year to summarize these findings. As PROs have observed, quality of care in hospitals has not deteriorated but has actually improved as a result of the PPS system. This finding has also been recently validated by the recent RAND study on the Impact of DRGs on Quality of Care. Instability at discharge has increased as a result of PPS but this problem is more a reflection of the limited Medicare benefit structure for post acute care services -- a problem made more pronounced by the tragic repeal of the Medicare Catastrophic Coverage Act of 1988. PROs have found only isolated instances of premature discharges that have seriously harmed the patient. The RAND study concluded that these two factors taken together - improved process of care within hospitals and increased severity of illness at discharge - offset each other in terms of the impact on patient outcome as measured by patient mortality.

Turning to utilization review, particularly PRO oversight of hospital admissions, there is also good news to report from a cost containment vantage point. Based on statistics compiled by the Prospective Payment Assessment Commission (PROPAC), it can be reported that admissions for the Medicare population increased steadily until 1983 and subsequently declined until 1986 at which time admissions have stayed relatively constant from year to year. The decline in overall volume of Medicare admissions from 1983 to 1989 was 5% and from 11.8 million in 1983 to 11.2 million in 1989. A more significant statistic to analyze in demonstrating the impact on hospital utilization is the per capita admission rate. From 1983 through 1989 the per capita admission rate fell by 15%, from a all time high of 431 per 1,000 beneficiaries in 1983 to 368 per 1,000 beneficiaries in 1989. This news is particularly heartening because the prevailing view held by experts at the start of PPS was that the incentives of the system would cause hospital admissions to increase given a global payment for each admission.

Without supporting empirical evidence, AMPRA does not claim that PRO review is the only or even the most importance causal factor for the decline in Medicare admissions since the

introduction of PRO oversight. Other variables, such as the shift of services to the outpatient sector and new technology have certainly played roles. We do believe, however, that PRO review has been an important contributing factor leading to the decline in hospital admissions.

Mr. Chairman, as we testified last year and would like to reiterate, much of PRO influence on the Medicare delivery system is not quantifiable. We believe the primary impact of the PRO Program to date has been to motivate and provide incentives for hospitals and other providers under review to invest in developing their own internal systems of quality assurance and utilization management. The PRO community has observed a pronounced increase in such institutional activity since the introduction of PRO review. As we reported last year, a clear example of the sentinel impact of PRO review was provided by PROPAC study conducted by Project Hope. A major finding of the report based on in-depth interview with hospital and hospital association representatives in 10 states, was the following:

> Many hospitals have begun their own preadmission review programs, with larger, urban, teaching hospitals more likely to be active in this area. In the case of Medicare admissions, well over half of the hospitals interviewed are performing preadmission review beyond that required by their PRO. Most of these are reviewing 100 percent of elective Medicare admissions. Hospitals also have preadmission review requirements for privately insured and managed care plan patients.
>
> The main reason motivating hospitals to conduct their own preadmission review of Medicare admissions is their desire to reduce the number of retrospective admission denials issued by their PRO. The reconsideration and appeals process is expensive for the hospital to undertake and a high denial rate may cause the hospital to be placed on intensified PRO review.

In summary, AMPRA agrees with the statement that you issued, Mr. Chairman, as part of the Press Release for this hearing. Your comment was that "Medicare does a better job of controlling costs than any other health insurance plan in the United States". We would add that this is most striking in examining Medicare inpatient costs. As reported by PROPAC in their recent report to Congress, during the six years before PPS, hospital inpatient expenditures grew at an annual rate of 17 percent. Over the first six years of PPS, the annual growth rate fell to 6.1 percent. While clearly these expenditures are a function of the DRG payment rates set by Congress they are also a function of the decreased volume of inpatient admissions. For this reason, we believe that there has been no cost containment program in the United States in recent years over a concentrated period of time that has been more successful than DRG payments complemented by PRO review. Price and volume controls were introduced as complementary strategies and a resulting 6.1 percent growth rate is proof enough of the success of the effort.

Mr. Chairman, your statement in the above mentioned Press Release is also sobering in that it reminds us all that more can be done to assure appropriate, high quality health care to Medicare beneficiaries. AMPRA agrees. We are committed to working with this Subcommittee, HCFA, all Medicare contractors, and other interested parties in improving Medicare oversight. On the inpatient side, more can be done to assure the appropriateness of hospital admissions. Quality review activities must remain vigilant particularly at a time when hospital operating margins are being threatened due to the constraint on DRG payments. Clearly much new quality and utilization oversight must accompany the delivery of Medicare Part B services. This is in reflection of the shift of services to the ambulatory setting, the rapid increase in Part B expenditures, and the introduction of the new physician payment reform. It is important to note that Medicare Part B expenditures have increased at an annual rate of 13.5% from 1983 to 1989, more than double the rate of Medicare inpatient expenditures. The point, is simply that there are always opportunities for improvement in Medicare oversight. With your challenge before us, I would like to take the remainder of my testimony to share with you AMPRA's thoughts for future improvements in the PRO Program.

New Directions for PRO Review

As already discussed, the first generation of the PRO program has been guided by a set of important but rather limited objectives. These objectives have been to oversee the introduction of the PPS system, control the volume of hospital admissions and project some level of confidence to Congress and the public that quality of care has not been compromised. The original PRO statutory objective, articulated by Senators Durenberger and Baucus, to empower local review organizations to innovate and to focus their activities on a broad range of quality and utilization objectives gave way to succeedingly prescribed PRO Scopes of Work, both in terms of the cases to be selected and the method by which review would be performed. Unfortunately, PRO review has been limited to a "snapshot" look at Medicare services. As we near the first decade anniversary of the implementation of PPS and with the broad success of PPS in terms of introducing incentives for hospital efficiency, it is now an appropriate time to move beyond this solitary focus and begin to pursue a more ambitious agenda. This new second generation of PRO review must explore new settings for review, new methodologies of review and new philosophies governing the relationship between HCFA, PROs and the provider community.

Mr. Chairman, let me comment that we are guided in this process of looking to the future by the 1990 report of the Institute of Medicine (IOM) entitled, "Medicare: A Strategy for Quality Assurance." The IOM took seriously its charge to outline a long term strategy for Medicare quality assurance and set a direction for the future that we can steer by in the years ahead. It is a very ambitious and difficult course that the IOM has chartered but let me state with confidence that it is a course that the PRO community can follow with enthusiasm. It is also a course that HCFA has publicly supported and it is garnering favorable reviews in other quarters as well, including the Senate Finance Committee. It appears that needed consensus is being generated regarding the longterm goals of Medicare oversight.

AMPRA is supportive of most of the conclusions and recommendations of the IOM study. We support the study's strong call for the development of a comprehensive database on patient care outcomes. The PRO community would like to be in the position in the future of linking more empirical evidence of medical effectiveness with the promulgation and dissemination by the PRO of more explicit process of care standards. We support the IOM strategy to feedback information to providers and patients to assist clinical decision making as a preferable alternative to regulatory oversight and the imposition of sanctions and penalties. It is not time, however, to relinquish PRO authority to sanction or penalize; these interventions can be needed stimulants to positive changes in behavior when other appeals to the provider community have not worked. The study's emphasis on continuous improvement as a means to shift practitioner behavior to a higher performance standard is strongly endorsed. It is true that too much time and too many resources have been expended in the PRO program chasing a relatively few outliers in the system. We are in agreement that identifying and rewarding provider performance needs to be encouraged in any Medicare quality assurance system. AMPRA fully supports the need to assure quality of care in all care settings and the call for additional funding to reach this goal. As previously mentioned, too much of the present PRO focus is on oversight of PPS at a time when services and technology are being dramatically shifted to the ambulatory setting. These and other recommendations of the IOM study are applauded by AMPRA, and as an Association we are committed to their implementation. The challenge is now to translate bold thematic goals and objectives into programmatic specifics. The PRO community is committed to assisting HCFA in realizing this difficult transition because we believe the end result will be a more efficient and effective external review system.

AMPRA Recommendations

In my presentation to this Subcommittee last June, AMPRA urged the Congress to make several changes in the PRO statute to improve the program. Mr. Chairman, I want to thank Subcommittee members because a number of these suggestions were subsequently adopted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). For example, important changes were made in the standard for assessing the willingness or ability of a

physician or provider to undertake a corrective action plan--a key consideration in any PRO's decision about the need to recommend sanctions. Congress also helped assure the confidentiality of PRO deliberations, and directed PROs to share information with medical licensing boards. Another provision calls for the development of a plan for improving coordination between PROs and Medicare carriers, including the development of common utilization and medical review criteria and improved methods for exchanging information. This last provision also mandates that a coordinated strategy of PRO and Part B Carrier targeted review in physician offices be implemented starting on January 1, 1992. This date, as you are aware Mr. Chairman, coincides with the introduction of the Resource Based Relative Value Scale (RBRVS) physician payment reform. AMPRA concurs with Congress that it is imperative that targeted review strategies be introduced to address quality and access concerns that might surface as a result of the new payment incentives. Unfortunately, we have not seen clear evidence that HCFA is moving to implement this provision and we ask for appropriate Subcommittee oversight. AMPRA recommends, as a modest starting point for evaluation of care provided in physician offices, the review of certain inpatient "sentinel" conditions that might represent a failure of ambulatory management or access problems. We note that this is the same approach that AMPRA recommended for the review of HMOs/CMPs.

At present, much of the attention of the PRO community is focused on the design of the 4th Scope of Work for the PRO program. This new effort is scheduled to begin for PROs in the first contract cycle on October 1, 1991. It is AMPRA's view that the 4th Scope of Work represents a critical opportunity to transition the present program from a largely regulatory orientation to a system that emphasizes epidemiologic oversight, focused peer review, and educational interaction with the medical community. Understanding the importance of this new contract cycle, the AMPRA Board of Directors recently adopted a PRO Program Policy Statement that is intended to facilitate discussion about short term programmatic efforts. The Policy Statement is included as an addendum to this written statement. I will now summarize our major recommendations.

First, we believe that PROs should be given much more flexibility in designing and implementing a review program that is consistent with the needs of their local areas. This kind of flexibility was clearly envisioned by Congress. Section 1154(4)(A) of the PRO statute stipulates:

> The organization shall, after consultation with the Secretary, determine (emphasis added) the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with respect to which such organization will, in order to most effectively carry out the purposes of this part, exercise review authority under the contract.

This legislative directive could easily be met by modifying HCFA's draft of the 4th PRO scope of work. In addition to performing a standard set of review tasks mandated by HCFA, PROs should be free to select a focused sample of up to 10 percent of hospital discharges as additional cases for review. In this fashion, PROs would be able to innovate, and to report back their experience, much in the same fashion that individual states act as laboratories under our federal system of government. AMPRA is confident that greater PRO discretion in case selection will lead to a higher yield of identified utilization and quality concerns. In addition, increased flexibility would allow PROs to shift their review focus away from providers with excellent track records and onto those who could most benefit from peer review. We would, of course, expect PROs to be held accountable for the review activities conducted under this more flexible approach.

Secondly, AMPRA recommends that PRO quality review and intervention requirements encourage non-punitive and educational feedback to care givers, rather that overly rely on a rigid and punitive scoring system. This is consistent with the IOM's recommendation to shift the emphasis of quality assurance away from a regulatory orientation to one that relies

on information feedback to both providers and consumers to motivate professionalism and patient responsibility.

Third, we believe that much more needs to be done to permit smooth implementation and effective use of the new Uniform Clinical Data Set (UCDS). Seven of AMPRA's members have played a key role as test sites for this new data collection and quality assurance tool. Their experience shows that additional steps must be taken to ensure inter-abstractor reliability, refine existing clinical algorithms, create new algorithms for areas not covered, reduce unnecessary referral rates, refine the system for its ultimate use as a tool of risk adjustment, and build administrative mechanisms to support training and system maintenance at a national scale.

As you probably know, UCDS, as presently configured, is more costly than the current review methodology. In fact, in its current form, UCDS triples the unit cost of PRO review. Because of this high cost, HCFA has proposed to reduce by half the projected volume of review in the PRO 4th scope of work. Among the work items proposed to be cut is pre-admission and pre-procedure review of selected physicians' services, an activity mandated under a provision of the Consolidated Omnibus Budget Reconciliation Act of 1985 but incompletely implemented to date. However, absent the development of implementing regulations, PROs have in the 3rd scope of work been required to conduct pre-procedure review of 10 different types of procedures selected from a HCFA-specified list of 13. The impact of this facet of the program has been poorly followed up and there are many in the PRO community that are concerned about the implications of discontinuing this type of review.

Unfortunately, HCFA's decision to abandon pre-procedure review appears to be premised, in large part, on the relatively low denial rates associated with the program, without the kind of more detailed evaluation we have recommended in the past. For example, my testimony before this Subcommittee last June 14th specifically observed that HCFA should "carefully analyze and compare surgical procedure use rates for similar time periods before and after the introduction of a prior authorization program." We request that such information be produced by HCFA and analyzed before a final decision is made on prior authorization review.

While AMPRA and its members are enthusiastic about working with HCFA toward implementation of UCDS, we also believe that there must be alternatives to UCDS if necessary refinements in the system cannot be made in time for the next scheduled implementation step. In our view, these alternatives--practice pattern analysis, focused peer review, and information feedback to providers and practitioners--would be better than too-early implementation of UCDS. We urge the Subcommittee to monitor the UCDS implementation plan very closely in order to assure that necessary changes in the system are made prior to more widespread use of this new tool.

Fourth, AMPRA recommends retaining the existing fixed price contracting arrangement in the PRO program which assures PRO accountability to a set of negotiated contract deliverables and objectives while minimizing administrative oversight of PRO operations.

In our Policy Statement AMPRA also recommends the following:

- A National Council on Medicare Quality Assurance should be established within the Department of Health and Human Services to provide advice about the implementation, operation and evaluation of Medicare review activities. This step was specifically recommended by the Institute of Medicine in its report "Medicare: A Strategy for Quality Assurance;"

- A private, freestanding, technical assistance center should be created for Medicare review contractors. This step was recommended by the Physician Payment Review Commission;

- The position of Associate Administrator for Medical Review should be created within HCFA and filled by a physician knowledgeable in the field of quality assurance, who would supervise the medical review components currently housed in the Bureau of Program Operations and the Health Standards and Quality Bureau.

All three of these steps would enhance the ability of the Department of Health and Human Services and the PRO community to build needed capacity and expertise as review technology becomes more and more sophisticated.

Mr. Chairman, allow me to briefly outline a few additional recommendations that we offer for Subcommittee consideration. AMPRA and its members are very interested in working with the Physician Payment Review Commission (PPRC) as it assumes new duties assigned in OBRA 1990--specifically, responsibility for making recommendations regarding "issues relating to utilization review and quality of care, including the effectiveness of peer review procedures and other quality assurance programs applicable to physicians and providers...and physician certification and licensing standards and procedures." Given this new charge, we believe that it would be important for the make-up of the Commission to better reflect the new areas of responsibility. We, therefore, urge the Committee to support the nomination of at least one representative of organizations involved in quality of care and utilization review. In addition, we believe that section 1845 of the Social Security Act should be amended to require the membership of the Commission to include representation from such organizations, even though this change is not absolutely required to allow for such an appointment. In our view, however, the change would send an important signal of the importance which the Congress attaches to the PPRC's new quality-related responsibilities.

AMPRA also once again recommends that HMOs and CMPs be required to assure the submission of inpatient discharge information necessary for PRO review efforts. As confirmed by a recent General Accounting Office investigation, the review of care provided to Medicare patients enrolled in HMOs and CMPs continues to be hampered by information gaps. HMOs and CMPs, and the hospitals they use, have not fully complied with the requirement to submit inpatient discharge information essential to the effective and efficient external review of care provided to such Medicare patients. We continue to believe that the responsibility for submitting inpatient discharge information belongs to the HMO or CMP, and we therefore urge the adoption of legislation that would require, as a condition of participation in the Medicare program, that HMOs/CMPs assure the submission of such discharge information. AMPRA also supports GAO's recommendation that HCFA be given intermediate sanction authority to force compliance with this information submission requirement.

Finally, we urge you to consider several technical corrections to the OBRA 1990 provision requiring PROs to exchange certain types of information with medical licensing boards. In the construction of the final bill, it appears that the type of information to be exchanged, the timing of the exchange and certain statutory citations were incorrectly stipulated. We believe that the provision should be amended to require PROs to exchange information with licensing boards at the point in time when the provider/practitioner has received a formal sanction notice and a quality problem has been confirmed by the PRO following a direct meeting.

Conclusion

Mr. Chairman, AMPRA appreciates this Subcommittee's continuing interest in the PRO program, and we look forward to working with you on the kinds of improvements in the program which will allow us to do a better job of addressing quality and appropriateness of care issues in the Medicare program.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Did I understand your definition of the new mission of the PRO is roughly the kind of mission that Dr. Wilensky has been describing where you focus more on patterns of practice and use that feedback into the medical community, a different sort of information to alter behavior?

Dr. BUSBY. Yes. We concur.

We feed information back for providers so there can be a catalyst for improving the quality of care.

Mrs. JOHNSON. Would you see in that new role the elimination of inappropriate care rather than nonpayment for care that you have deemed inappropriate?

Dr. BUSBY. The new PRO would still have to have the sanction authorities and you would have to look at the appropriate care as well as the overall role of improving quality care. I am not sure I understand your question.

Mrs. JOHNSON. I would hope that as a consequence of this new approach there would be a reduction in care for which reimbursement was denied. This would mean that the system would not waste resources in providing it and then be stuck with nonpayment.

Presumably, this new approach will in a sense prospectively oversee care and eliminate inappropriate or unnecessary care and, therefore, reduce costs, not just in the reimbursement arena but in the real world of user resources.

Dr. BUSBY. That is true. USDS, through the epidemiological data base, can tell us the most appropriate ways of treating some things. We believe, and I believe Gail Wilensky does also, that the premise of this is that if you provide information to practitioners and providers regarding the most appropriate forms of treatment that that is what you will get.

Mrs. JOHNSON. Have you had experience as an organization of being able to elicit patterns of practice from your position of review and feeding that back into the medical community? Have you seen changes?

Dr. BUSBY. We have through the small area analysis program. It was a trial basis and somewhat limited. The plan, looking at pattern analysis on a geographic basis, may also do the same thing, looking at key areas, looking at high use and low use areas and trying to pull together a group to find the problems of that and improve the appropriateness of care provided.

Mrs. JOHNSON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. I want to thank both of you for your testimony.

There is kind of the chicken or the egg dilemma that we go through as you heard earlier. If we increase funding for the IRS audits, we get more money back. I would be surprised if the IRS ever came before the committee and testified that they don't need the money and are going to give some of our budget back. That is not in their nature. Few of us do it with our own salaries and I don't think it is in the bureaucratic nature of the IRS to do it. So I am not suggesting that you do it.

Mr. Kusserow suggested that 87 fiscal intermediaries are too many and if we reduce this number we will become more efficient

and have better control over the program spending. Mr. Cohodes, what do you think about that?

Mr. COHODES. Medicare, particularly for intermediaries and carriers, is a volume-driven program. Whether you have 85 or 20 carriers, that volume will remain. About the only thing you are likely to see is a marginal savings in overhead between and among contractors. HCFA's past experience in consolidating contractors supports this observation.

Chairman STARK. That would be true if everything was uniform—uniform forms, uniform accounting practices, uniform data processing. But it is my understanding that everybody does it differently. Therefore, from the standpoint of the person who has to inspect these records, he has to have 87 different manuals to do it.

Mr. COHODES. He has a terrible problem. It is a problem that stems from the absence of uniform policy. I would say some of those decisions are difficult decisions for HCFA and for the administration. For instance, do we have a national medical policy or do we want to recognize local variation in medical practice as being legitimate? That is an honest issue to debate. So far, Medicare has said they will recognize local variation.

If you adopt nationwide standards, you could apply them but in that absence, you have the complexity and lack of uniformity.

With regard to the system, it is, again, one of the oddities——

Chairman STARK. When you say different practice patterns, I wonder if there is much difference. I mean, you have enough doctors and enough categories for physician reimbursement. I have heard statistics that in one city with regard to child delivery, one community may use cesarean births 10 times more often than another city. That is a habit of practice. Nobody can figure out why, but they do it more often in one place than another. That is an issue of volume.

Is there any reason why we should pay any more for a cesarean operation in one city or another?

Mr. COHODES. No.

Chairman STARK. I have a hunch that that is mostly where the difference of practice is. Some communities have a procedure that is unknown to all the other 49 States. It is that they may use it more or less.

Mr. COHODES. As the chairman is well aware, we have embarked on the process of paying the same on the physician side of the equation. That should bring greater uniformity.

Chairman STARK. Are you aware of the eight new data processing things?

Mr. COHODES. Yes, sir.

Chairman STARK. Can you explain it to me?

Mr. COHODES. I will try. I am not sure if you are referring to the common working file, which is the regionalized eligibility and beneficiary files or to claims processing.

Chairman STARK. The claims processing. They are 9 months behind in some areas in getting paid.

Mr. COHODES. I am not familiar with that, sir.

Chairman STARK. Is it the Florida program?

Mr. COHODES. It is the Florida standard system.

Chairman STARK. That is for Medicare claims processers with large volumes which is why it is going to New York, California, Florida.

Mr. COHODES. That is right. I believe some other States are in line to acquire the system.

Chairman STARK. Isn't it being demanded?

Mr. COHODES. Let's put it this way. HCFA is creating strong incentives for contractors to implement those systems. What has taken place is that some of the systems that are now in place are geared to a certain volume of handling claims. The basic system that is used by most Medicare contractors is called the Arkansas system which is the host site of this. There are 20 contractors who use that system.

When there was an attempt to expand that system to handle a greater volume of claims, the system broke down. It could not handle the large numbers or complexities. As a result, HCFA urged the development of a standardized claims processing system for large volume contractors. Florida was the first choice. The first implementation site was California. As I understand it that has not been the most successful implementation in history, partly due to the speed HCFA wanted it to take place and partly because it was an initial system implementation.

I understand the hospital associations from Florida and California have met with HCFA on this and next week there will be a gathering of the hospitals and associations to work out the remaining concerns about that system.

Chairman STARK. Let's assume the Florida system will work and you run parallel long enough so you can work out the bugs. Like any new one, it is maddening. It doesn't work right, not fast enough and costs 10 times more than you ever dreamed it could. But if this is the largest volume system, then you are going to have trouble suggesting to me that a system that will handle a large volume cannot handle a modest volume.

Mr. COHODES. I have gone to my system people and asked a similar question, but it is also driven by the different types of claims that one has.

Chairman STARK. Wouldn't it make some sense to you instinctively that what we ought to do is hold up a minute because we are not going to change all this billing over night and get one system that works?

Now, if that one system is big enough to handle the biggest volumes, let's make sure everybody is comfortable with it. Then we can proceed to get whatever standardization we can by applying it a State at a time, say, next to the Arkansas group rather than simultaneously developing on purpose what will necessarily evolve.

Mr. COHODES. There are times, sir, it doesn't make a lot of sense. History is a good guide. Near the inception of the program there was an attempt to develop one standard Medicare system. Over half of the intermediaries were using it. HCFA became concerned that they would be dependent on the vendor for that one system and they wanted multiple options to have backups in case that system did not work. All of a sudden, it proliferated.

Chairman STARK. That was in an era when a computer necessary to handle that would have filled this room.

Mr. COHODES. That is correct.

Chairman STARK. Today that same computer, you and I could carry in a briefcase on the airlines. So that historical reference does not take into account the other statement that Inspector General Bowsher said we are not getting and that is the benefit of the learning curve.

Today, it is the software. If the software works in your PC, it will work in my PC. We don't have to worry about the phone lines going down.

So I would ask that question again, given the state of the technology and the almost pervasive presence of computers within the 6,000 hospitals, and we are talking about hospitals in this instance, wouldn't it make sense that we would be better off starting at least with a uniform system and getting into work?

Mr. COHODES. I think it would make more sense.

One of the reasons I think we have not reached that gets back to how HCFA plans, and the resources necessary to develop the prototype. Each year when the budget comes out one of the things that is skimped on is the productivity investment area, which is the part of the contractor's budget that supports system changes. There is more of a problem on the part B side where the system divergence is far wider between and among contractors.

There are no public domain usable systems to share. That is really a major problem.

Chairman STARK. As I say, it is troubling to me. It seems to be one of these things that gets pushed aside. It would certainly make all our lives simpler or more precise.

Mr. COHODES. It would make mine, too, sir.

Chairman STARK. I thank you. Maybe we can make a little progress along that line in time to come.

I want to thank you both for your help. We appreciate it.

We will now call on our second panel, including representatives of two providers' groups. We are pleased to welcome Corrine Parver, president, National Association of Medical Equipment Suppliers, and Hope Foster, general counsel, American Clinical Laboratory Association.

Corrine, would you like to lead off?

STATEMENT OF CORRINE PARVER, PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

Ms. PARVER. I would like to request our written remarks be made a part of the record.

Chairman STARK. Without objection.

Ms. PARVER. Mr. Chairman, my name is Corrine Parver. I am president of the National Association of Medical Equipment Suppliers, a nonprofit association representing more than 2,000 HME suppliers operating in over 4,000 facilities nationwide.

Based upon individual patient needs and only according to physicians' prescriptions, our members furnish a wide variety of equipment, supplies, and services for home use. These items may range from traditional medical equipment such as hospital beds, to highly sophisticated items and services such as parenteral and enteral supplies, which provides nutrition via equipment to individuals

who cannot eat normally; apnea monitors, which allow parents to closely guard high-risk infants' breathing; and wheelchairs and other technologically advanced equipment, which are custom designed for the needs of rehabilitation patients. A substantial portion of HME clients are Medicare and Medicaid beneficiaries.

Medicare expenditures for the HME benefit currently amount to just under $2 billion, and have remained between $1.8 and $2 billion for the last few years due to budget cuts achieved through annual budget reconciliation acts. HME outlays represent approximately 2 percent of total Medicare program expenditures.

My testimony today focuses on two main issues: How, together, we must mount an effective program to address the issue of fraud and abuse in the HME industry through legislation and consumer education, thereby ensuring quality care and ethical behavior; and the benefits and value of HME in our Nation's health care system.

First, I want to emphasize that NAMES strongly supports efforts to eliminate unethical practices in the Medicare program, generally, and the home medical equipment industry, specifically. Legitimate HME suppliers, which comprise most of the industry, have a common interest with policymakers, and that is to stop all unethical business practices. We hope that you will give serious consideration to incorporating into your efforts the comprehensive ethics legislation for the HME industry that NAMES helped develop.

On June 4, 1991, Representative Ben Cardin, Democrat from Maryland, introduced the NAMES-sponsored "Ethics in Home Medical Equipment Act of 1991," H.R. 2534. This unprecedented legislation would close loopholes in current Medicare law which have led to questionable practices in some cases some of you alluded to earlier this morning, particularly when Dick Kusserow was talking about forum shopping.

H.R. 2534 would help insure that all HME suppliers meet the high standards that the overwhelming majority of them do already, by requiring adherence to strict standards of practice under the Medicare program. Any assumption that the entire industry is violating standards of ethics simply is not true. As well, the legislation would encourage accreditation of HME suppliers and, unlike what occurs today, would bar participation in Medicare for noncertified suppliers.

We have a common interest, Mr. Chairman: To rid the HME industry of those few unscrupulous suppliers whose conduct we are focusing on today. Admittedly, the bill we are supporting is a tough bill. But if Congress is serious—as NAMES is—about weeding out the few suppliers who tarnish the reputation of a growing, conscientious and valuable industry, then this is the kind of tough but sensible action Congress needs to take. We are very hopeful that this important and far-reaching legislation introduced by Representative Cardin will receive prompt consideration.

It is important to remember that home medical equipment and services comprise a vital and cost-effective component of our Nation's home health care system. HME products and services help make homecomings possible for so many elderly, disabled, or ill individuals who can be discharged earlier from more costly hospitals or other institutions if they have appropriate medical equipment to assist them at home. It is also the HME industry which provides

products and services to enable quadriplegics, paraplegics, and other people with severe disabilities to lead productive lives in the mainstream of society with the aid of appropriate medical equipment.

Throughout our discussions today, let us not lose sight of the fact that HME as a part of home health care offers a practical alternative to the continuing high costs of institutionalization and allows for an enhanced quality of life. A May 1991 national survey conducted by National Research, Inc., shows that almost 75 percent of Americans would prefer to be taken care of at home if recuperating from a serious accident or illness.

As our Nation's elderly population increases and as further technological advances are made to help empower people with disabilities to realize their unique potential, policymakers should recognize HME as an effective, efficient, and undeniably compassionate mechanism for providing care in the home. And as chair of the Health Subcommittee of the House Ways and Means Committee, you know only too well what institutional costs are under the Medicare program.

Savings and cost-effectiveness are an important social benefit provided by the HME industry. But those tangible gains are by no means the only or even perhaps the most substantial social benefits conferred by an industry that helps to allow people to live, recuperate, and continue with their lives at home with their families and friends.

Ethical HME suppliers do much more than just deliver home Medical equipment to Medicare beneficiaries and others. They set up the equipment, train patients and their care givers on how to use the equipment properly, service the equipment 24 hours a day, every day and complete expensive, ever increasing Medicare paperwork for their patients. This high level of home care service must be encouraged, not destroyed.

However, in addition to the clear benefits for millions of Americans as a direct result of this home care industry, I must candidly acknowledge the reports of fraudulent and abusive practices by some unscrupulous people who have orchestrated so-called scam telemarketing operations or engaged in other unethical business practices under the guise of operating an HME company.

It is for this reason that I am particularly pleased to appear before the committee today to address NAMES' ongoing efforts to help eliminate unethical practices by: educating consumers about their rights and responsibilities involving the rental or purchase of HME; suggesting a legislative solution to this problem; and describing ways in which Congress can assist in eliminating the relatively few unethical suppliers who not only damage an otherwise quality industry, but also cause unnecessary Federal expenditures and, in so doing, exploit the elderly.

Only a small percentage of suppliers may engage in fraudulent and abusive practices. We need to develop an effective program to define and eliminate unethical behavior. While the actual numbers of HME suppliers sanctioned by the Health and Human Services' Office of Inspector General—OIG—in recent years has been relatively few—approximately 3.8 percent of total OIG sanctions for 1990—we are concerned that an industry which traditionally pro-

vides such a high level of quality and personalized service is tarnished by the actions of a few unethical companies. Thus, NAMES is supporting a tough, effective and multifaceted program. Some of it we can and are doing within NAMES. But for part of the program, we need Congress' help.

Mr. Chairman, NAMES firmly believes that even one beneficiary hurt in any way by an unscrupulous company is one too many. Even one company engaging in unethical business practices tarnishes the reputation of the legitimate HME industry and causes unnecessary expenditures of Medicare dollars. That is why NAMES has taken a strong and active stand against potentially fraudulent and abusive practices in the HME industry.

NAMES is supporting H.R. 2534, a strong legislative proposal to address explicitly the problem of unethical practices in the HME industry. The "Ethics in Home Medical Equipment Act of 1991" promotes ethical conduct in the HME industry and, when enacted, will help eliminate instances of Medicare fraud and abuse.

This legislation would allow only those HME suppliers who meet certain minimal standards established by the Department of Health and Human Services to provide services under the Medicare program.

In the past, the Medicare program's reimbursement methodology allowed for significant variations from State to State in the amounts paid for similar items of home medical equipment, services, and supplies. This practice accounted for some of the historical pricing differences for HME items and, in fact, has encouraged the practice of carrier/forum shopping.

A move to regional carriers would help eliminate this problem. Requiring a supplier to bill for items to the carrier responsible for the area in which the beneficiary resides, a provision in H.R. 2534, conclusively would put an end to carrier shopping in this industry.

Mr. Kusserow said OIG supports this provision. It certainly will deal with the TENS suppliers.

As you know, Congress abolished payment for HME according to the old reasonable charge methodology in OBRA 1990 and substituted fee schedule payment in its stead. Thus, HME now is reimbursed according to a phasedin national fee schedule.

By 1993, the pricing disparities between costs on the one hand and Medicare payment amounts in various States on the other will disappear, due to the completed phasein of national pricing.

Other provisions in H.R. 2534 strengthen and tighten the Medicare statute in certain instances and provide a measure of needed legislative relief for the HME industry from some of the more egregious effects of OBRA 1990.

Additional efforts we have engaged in to promote ethical business practices include the following: In 1987, NAMES created a code of ethics that establishes principles of ethical conduct. This code helps ensure that HME companies provide quality care to all patients. We amended our bylaws recently to permit expulsion of any member convicted of a felony or sanctioned under the Medicare program. To date, we never have had to invoke this particular bylaw provision.

Importantly, NAMES recently developed and distributed to all members a guide for conduct which further strengthens the code of

ethics. The guide helps members determine the propriety of their conduct, so that they are clear on what is, and what is not, sound, ethical business practices. We also published a strong sample statement of patient rights and responsibilities.

NAMES produced two consumers' rights brochures, which describe how to rent or purchase HME items. Entitled "A Shopper's Guide to Home Medical Equipment" and ". . . Check With Your Health Professional First," thousands of brochures already have been purchased by NAMES members who distribute them to hospital discharge planners, physicians, therapists and their clients, the consumer.

Information included in these brochures features reasons why consumers should seek advice from a health professional before buying or renting medical equipment. The brochures explain consumers' rights, what they should do if an unsolicited company tries to sell them equipment or if they receive a product that their doctor did not approve, and where they could report fraudulent behavior. We believe that educated consumers attack unethical suppliers where it hurts the most: in the marketplace. With your permission, I would like to enter copies into the record.

As the only national association representing HME suppliers exclusively, NAMES and its 38 State and regional affiliates remain committed to working actively with Congress and the administration to help eliminate unfair practices within the HME industry. But the measures that I have just described, quite simply, are not sufficient. We need Congress' help in further enforcing ethical norms against the few whose actions tarnish the many.

Mr. Chairman, you cannot legislate morality. But you can close some of the existing loopholes that permit unethical practices. For that reason, NAMES urges Congress to study carefully the HME ethics bill, H.R. 2534, and enact such legislation as expeditiously as possible. Creating standards of practice and encouraging accreditation for all HME suppliers would serve as an overall quality assurance and quality improvement control mechanism for the industry.

In a related matter, Congress last year in OBRA 1990 imposed harsh reimbursement cuts to the HME benefit in an effort to help reduce the Federal budget deficit. Certain provisions in OBRA 1990 have made it increasingly difficult for legitimate HME suppliers to continue providing the traditional level of quality care to Medicare beneficiaries.

Unethical suppliers, however, are affected only minimally by these actions. Since terms such as "customer service," "quality," and "honesty" likely are not part of their vocabulary, the lack of an equitable level of Medicare reimbursement which allows for high quality service becomes meaningless. We are concerned that the deep OBRA 1990 reimbursement reductions for HME may well have the unforeseen effect of further reducing patient access to quality care, as legitimate HME suppliers are forced to cease or curtail providing certain services altogether, thereby further "opening the door" to inferior or otherwise shoddy suppliers. Certain provisions in the bill address this issue. You can close some existing loopholes by enacting H.R. 2534.

One other thing I would like to mention, because certain of the reimbursement cuts in OBRA 1990 have made it difficult for legiti-

mate suppliers to provide the care to Medicare beneficiaries. We are doubly concerned because the unethical suppliers don't pay attention to quality care, good service, maintaining access. We want you to please focus some attention on that as we go through this legislative session and the next.

To summarize, NAMES joins you in your concerns about unethical business practices in the HME industry. We welcome hearings on such an important issue.

The HME industry is a valuable, increasingly vital element in our Nation's health care system. This industry truly helps make homecomings possible. In an era of increasing cost consciousness and concern about the long-term care of our Nation's elderly and people with disabilities, it makes plain policy sense to preserve the very benefit that provides home health care services in the most cost-effective and yet compassionate fashion. But it is likewise a policy necessity to fashion educational and legislative safeguards against those who would abuse Medicare and its beneficiaries.

Instances of fraud and abuse perpetrated on unsuspecting beneficiaries must be eliminated. To do this requires a combined effort on the part of industry, Congress, the administration, and beneficiaries. NAMES supports the OIG's efforts to investigate thoroughly but promptly all instances of potentially fraudulent business practices and take appropriate actions or refer allegedly criminal cases for prosecution.

A well-informed beneficiary is the most desired deterrent to Medicare "scam" operations. Diligent investigations and enforcement on the part of appropriate Government entities, OIG, in particular, and sound input from industry experts well-versed in HME also are keys to success.

NAMES remains extremely concerned that, currently, the overall investigative process is inordinately slow, time-consuming and somewhat unresponsive.

We are committed to help ensure that all member companies act ethically. We will continue to take the lead in addressing unethical practices through education, cooperation with OIG and HCFA and, hopefully this year with your help, through passage of H.R. 2534.

NAMES looks forward to working together with Congress and the administration to help solve these problems. We welcome the opportunity to appear before any other appropriate forum to discuss the specific components of our legislative proposals or to meet individually with members of this committee and their staffs.

I will be happy to answer any questions you may have and ask that you include my comments in the official hearing records.

[The prepared statement follows:]

TESTIMONY
OF
CORRINE PARVER
PRESIDENT
NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS
ON
ETHICS IN THE HOME MEDICAL EQUIPMENT INDUSTRY
BEFORE THE
HOUSE WAYS AND MEANS COMMITTEE
HEALTH SUBCOMMITTEE
HEARING
OF
JUNE 13, 1991

Mr. Chairman and Members of the Committee: I am pleased to appear today to discuss ethics, appropriate business practices and quality standards in the home medical equipment (HME) industry. My name is Corrine Parver. I am President of the National Association of Medical Equipment Suppliers (NAMES), a non-profit association representing more than 2,000 HME suppliers operating in over 4,000 facilities nationwide.

Based upon individual patient needs and only according to physicians' prescriptions, our members furnish a wide variety of equipment, supplies and services for home use. These items may range from traditional medical equipment such as hospital beds, to highly sophisticated items and services such as parenteral and enteral supplies, which provide nutrition via equipment to individuals who cannot eat normally; apnea monitors, which allow parents to closely guard high risk infants' breathing; and wheelchairs and other technologically-advanced equipment, which are custom-designed for the needs of rehabilitation patients. A substantial portion of HME clients are Medicare and Medicaid beneficiaries.

Medicare expenditures for the HME benefit currently amount to just under $2 billion, and have remained between $1.8 and $2 billion for the last few years due to budget cuts achieved through annual budget reconciliation acts. Hme outlays represent approximately 2% of total Medicare program expenditures.

My testimony today focuses on two main issues:

- How, together, we must mount an effective program to address the issue of fraud and abuse in the HME industry through legislation and consumer education, thereby ensuring quality care and ethical behavior; and
- The benefits and value of HME in our nation's health care system.

First, I want to emphasize that NAMES strongly supports efforts to eliminate unethical practices in the Medicare program, generally, and the home medical equipment industry, specifically. Legitimate HME suppliers, which compromise most of the industry, have a common interest with policy makers, and that is to stop all unethical business practices. We hope that you will give serious consideration to incorporating into your efforts the comprehensive ethics legislation for the HME industry that NAMES helped developed.

On June 4, 1991, Representative Ben Cardin (D-MD) introduced the NAMES-sponsored "Ethics in Home Medical Equipment Act of 1991," H.R. 2534. This unprecedented legislation would close loopholes in current Medicare law which have led to questionable practices in some cases. Most important, H.R. 2534 would help ensure that all HME suppliers meet the high standards that the overwhelming majority of them do already, by requiring adherence to strict standards of practice under the Medicare program. Any assumption that the entire industry is violating standards of ethics simply is not true. As well, the legislation would encourage accreditation of HME suppliers and, unlike what occurs today, would bar participation in Medicare for non-certified suppliers.

We have a common interest, Mr. Chairman: to rid the HME industry of those few unscrupulous suppliers whose conduct we are focusing on today. Admittedly, the bill we are supporting is a tough bill. But if Congress is serious -- as NAMES is -- about weeding out the few suppliers who tarnish the reputation of a growing, conscientious and valuable industry, then this is the kind of tough but sensible action Congress needs to take. We are very hopeful that this important and far-reaching legislation introduced by Rep. Cardin will receive prompt consideration.

It is important to remember that home medical equipment and services comprise a vital and cost-effective component of our nation's home health care system. HME products and services help make homecomings possible for so many elderly, disabled or ill individuals who can be discharged earlier from more costly hospitals or other institutions if they have appropriate medical equipment to assist them at home. It is also the HME industry which provides products and services to enable quadriplegics, paraplegics and other people with severe disabilities to lead productive lives in the mainstream of society with the aid of appropriate medical equipment.

Throughout our discussions today, let us not lose sight of the fact that HME as a part of home health care offers a practical alternative to the continuing high costs of institutionalization and allows for an enhanced quality of life. A May 1991 national survey conducted by National Research, Inc. shows that almost 75 percent of Americans would prefer to be taken care of at home if recuperating from a serious accident or illness.

As our nation's elderly population increases and as further technological advances are made to help empower people with disabilities to realize their unique potential, policy makers should recognize HME as an effective, efficient and undeniably compassionate mechanism for providing care in the home. And, as Chair of the health subcommittee of the House Ways and Means Committee, you know only too well what institutional costs are under the Medicare program.

Savings and cost-effectiveness are an important social benefit provided by the HME industry. But those tangible gains are by no means the only or even perhaps the most substantial social benefits conferred by an industry that helps to allow people to live, recuperate and continue with their lives at home with their families and friends.

Ethical HME suppliers do much more than just deliver home medical equipment to Medicare beneficiaries and others -- they set up the equipment, train patients and their caregivers on how to use the equipment properly, service the equipment 24 hours-a-day, every day and complete expensive, ever increasing Medicare paperwork for their patients. This high level of home care service must be encouraged -- not destroyed.

However, in addition to the clear benefits for millions of Americans as a direct result of this home care industry, I must candidly acknowledge the reports of fraudulent and abusive practices by some unscrupulous people who have orchestrated so-called "scam" telemarketing operations or engaged in other unethical business practices under the guise of operating an HME company.

It is for this reason that I am particularly pleased to appear before the Committee today to address NAMES ongoing efforts to help eliminate unethical practices by: educating consumers about their rights and responsibilities involving the rental or purchase of HME; suggesting a legislative solution to this problem; and describing ways in which Congress can assist in eliminating the relatively few unethical suppliers who not only damage an otherwise quality industry, but also cause unnecessary federal expenditures and, in so doing, exploit the elderly.

Only a small percentage of suppliers may engage in fraudulent and abusive practices. We need to develop an effective program to define and eliminate unethical behavior. While the actual numbers of HME suppliers sanctioned by the Health and Human Services' Office of Inspector General (OIG) in recent years has been relatively few (approximately 3.8 percent of total OIG sanctions for 1990), we are concerned that an industry which traditionally provides such a high level of quality and personalized service is tarnished by the actions of a few unethical companies. Thus, NAMES is supporting a tough, effective and multi-faceted program. Some of it we can and are doing within NAMES. But for part of the program, we need Congress' help.

Mr. Chairman, NAMES firmly believes that even one beneficiary hurt in any way by an unscrupulous company is one too many. Even one company engaging in unethical business practices tarnishes the reputation of the legitimate HME industry and causes unnecessary expenditures of Medicare dollars. That is why NAMES has taken a strong and active stand against potentially fraudulent and abusive practices in the HME industry.

NAMES is supporting H.R. 2534, a strong legislative proposal to address explicitly the problem of unethical practices in the HME industry. The "Ethics in Home Medical Equipment Act of 1991" promotes ethical conduct in the HME industry and, when enacted, will help eliminate instances of Medicare fraud and abuse.

This legislation would allow only those HME suppliers who meet certain minimal standards established by the Department of Health and Human Services to provide services under the Medicare program.

Such standards would include:

* the establishment of patients' rights and responsibilities;
* requirements for the notification of patients of their rights and responsibilities;
* patient care;
* safety management and infection control;
* quality assurance;
* administration;
* clinical services (where applicable); and
* equipment management.

H.R. 2534 encourages voluntary accreditation of HME suppliers by a duly authorized accrediting body by permitting "deemed status" for those suppliers who already have completed a rigorous process of accreditation by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Community Health Accreditation Program (CHAP). Additionally, strong sanctions would be applied against those individuals who engage in activities such as forum/carrier shopping. A clause prohibiting physician self-referral also exists.

In the past, the Medicare program's reimbursement methodology allowed for significant variations from state to state in the amounts paid for similar items of home medical equipment, services and supplies. This practice accounted for some of the historical pricing differences for HME items and, in fact, has encouraged the practice of carrier/forum shopping. A move to regional carriers would help eliminate this problem. Requiring a supplier to bill for items to the carrier responsible for the area in which the beneficiary resides -- a provision in the H.R. 2534 -- conclusively would put an end to carrier shopping in this industry.

As you know, Congress abolished payment according to the old reasonable charge methodology in OBRA 1990 and substituted fee schedule payment in its stead. Thus, HME now is reimbursed according to a phased-in national fee schedule. By 1993, the pricing disparities between costs on the one hand and Medicare payment amounts in various states on the other will disappear, due to the completed phase-in of national pricing.

Other provisions in H.R. 2534 strengthen and "tighten" the Medicare statute in certain instances and provide a measure of needed legislative relief for the HME industry from some of the more egregious effects of OBRA 1990.

Additional efforts we have engaged in to promote ethical business practices include the following: In 1987, NAMES created a Code of Ethics that establishes principles of ethical conduct. This Code helps ensure that HME companies provide quality care to all patients. We amended our bylaws recently to permit expulsion of any member convicted of a felony or sanctioned under the Medicare program. To date, we never have had to invoke this particular bylaw provision.

Importantly, NAMES recently developed and distributed to all members a Guide for Conduct which further strengthens the Code of Ethics. The Guide helps members determine the propriety of their conduct, so that they are clear on what is -- and what is not -- sound, ethical business practices. We also published a strong sample Statement of Patient Rights and Responsibilities.

NAMES produced two consumers' rights brochures, which describe how to rent or purchase HME items. Entitled "A Shopper's Guide to Home Medical Equipment" and "...Check with your health professional first", thousands of brochures already have been purchased by NAMES members who distribute them to hospital discharge planners, physicians, therapists and their clients -- the consumer.

Information included in these brochures features reasons why consumers should seek advice from a

health professional before buying or renting medical equipment. The brochures explain consumers' rights, what they should do if an unsolicited company tries to sell them equipment or if they receive a product that their doctor did not approve, and where they could report fraudulent behavior. We believe that educated consumers attack unethical suppliers where it hurts the most: in the marketplace. With your permission, I would like to enter copies into the record.

As the only national association representing HME suppliers exclusively, NAMES and its 38 State and Regional affiliates remain committed to working actively with Congress and the Administration to help eliminate unfair practices within the HME industry. But the measures that I have just described, quite simply, are not sufficient. We need Congress' help in further enforcing ethical norms against the few whose actions tarnish the many.

Mr. Chairman, you cannot legislate morality. But you can close some of the existing loopholes that permit unethical practices. For that reason, NAMES urges Congress to study carefully the HME ethics bill, H.R. 2534, and enact such legislation as expeditiously as possible. Creating standards of practice and encouraging accreditation for all HME suppliers would serve as an overall quality assurance and quality improvement control mechanism for the industry.

In a related matter, Congress last year in OBRA 1990 imposed harsh reimbursement cuts to the HME benefit in an effort to help reduce the Federal budget deficit. Certain provisions in OBRA 1990 have made it increasingly difficult for legitimate HME suppliers to continue providing the traditional level of quality care to Medicare beneficiaries.

Unethical suppliers, however, are affected only minimally by these actions. Since terms such as "customer service", "quality" and "honesty" likely are not part of their vocabulary, the lack of an equitable level of Medicare reimbursement which allows for high quality service becomes meaningless. We are concerned that the deep OBRA 1990 reimbursement reductions for HME may well have the unforseen effect of further reducing patient access to quality care, as legitimate HME suppliers are forced to cease or curtail providing certain services altogether, thereby further "opening the door" to inferior or otherwise shoddy suppliers. Certain provisions in the bill address this issue.

In summary, Mr. Chairman, NAMES joins you in your concerns about unethical business practices in the HME industry. We welcome hearings on such an important issue.

The HME industry is a valuable, increasingly vital element in our nation's health care system. This industry truly helps make homecomings possible. In an era of increasing cost-consciousness and concern about the long-term care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve the very benefit that provides home health care services in the most cost-effective and yet compassionate fashion. But it is likewise a policy necessity to fashion educational and legislative safeguards against those who would abuse Medicare and its beneficiaries.

Instances of fraud and abuse perpetrated on unsuspecting beneficiaries must be eliminated. To do this requires a combined effort on the part of industry, Congress, the Administration and beneficiaries. NAMES supports the OIG's efforts to investigate thoroughly but promptly all instances of potentially fraudulent business practices and take appropriate actions or refer allegedly criminal cases for prosecution.

A well-informed beneficiary is the most desired deterrent to Medicare "scam" operations. Diligent investigation and enforcement on the part of appropriate government entities -- OIG in particular -- and sound input from industry experts well-versed in HME also are keys to success. NAMES remains extremely concerned that, currently, the overall investigative process is inordinately slow, time-consuming and somewhat unresponsive.

We are committed to help ensure that all member companies act ethically. We will continue to take the lead in addressing unethical practices through education, cooperation with OIG and HCFA and, hopefully this year with your help, through passage of H.R. 2534.

NAMES looks forward to working together with Congress and the Administration to help solve these problems. We welcome the opportunity to appear before any other appropriate forum to discuss the specific components of our legislative proposals or to meet individually with Members of this Committee and their staffs.

I will be happy to answer any questions you may have and ask that you include my comments in the official hearing records.

STATEMENT OF HOPE FOSTER, GENERAL COUNSEL, AMERICAN CLINICAL LABORATORY ASSOCIATION

Chairman STARK. Ms. Foster.

Ms. FOSTER. Good morning, Mr. Chairman and members of the subcommittee. This has been a long and very interesting morning. I am sure we are all hungry and anxious to go to lunch. I will be brief.

Since 1984, ACLA has often appeared before you to offer our views about how to help lower the federal deficit through equitable reductions in Medicare outlays. We appear here today in the same spirit of cooperation. We must all work together to develop intelligent mutually acceptable proposals to solve the problems that have been created by a distorted marketplace. ACLA welcomes this opportunity and pledges to continue the process we began so long ago.

We are concerned, however, that the proposals that have been recently offered will create more problems than they will cure, and will injure the very people that the Medicare program was designed to protect, the elderly and disabled.

In reviewing these proposals it is important to remember that testing provides a valuable service that saves money and minimizes pain and suffering through early diagnosis and treatment of disease. President Bush's condition would not have been diagnosed without lab tests.

It is also important to remember that testing, at least when performed by independent labs, is a bargain. Government reports suggested in 1990 Medicare spent only $42 per beneficiary for testing performed by independent labs. In comparison per beneficary expenditures for physician services were $1,100.

You have been presented with several proposals, one from the GAO and another from OIG. They suggest widely divergent approaches. Although ACLA has not had an opportunity to analyze the GAO study, it apparently shows that some laboratories earn more on Medicare testing than on testing provided to physicians for their non-Medicare patient testing. The GAO has identified a key structural problem in the industry, a problem that ACLA itself discussed just last year in testimony before you. Because labs cannot order testing without a physician's order, doctors can force labs to provide large discounts on non-Medicare work which some physicians may then mark up when billing patients and third-party payers. This structural problem demands a structural solution, implementation of a direct billing mandate which will remove physicians from their role as brokers of lab testing. As we told you last year, experience suggests that enactment of such a requirement could lower the price of testing to patients and third-party payers. Medicare is, of course, an especially important insurer that will reap the benefits of such a structural solution.

Many studies confirm that when physicians have a stake in lab testing, utilization is affected. Mark up is just such a financial stake. The 1989 self-referral studies by the OIG and GAO established that physicians with financial interests in labs order more tests. When Nevada barred physicians from billing for lab tests for Medicaid patients, utilization fell almost 48 percent. Labs in direct billing States, like New York and Michigan, charge patients less

for tests than in comparable nondirect billing States. Direct billing builds on the same principle that underlie the self-referral ban. Physicians should not benefit financially from tests they do not perform.

The OIG's laboratory roll-in, or LRI, proposal is a radical alternative based on faulty data and inadequate analysis. Under LRI, Medicare would increase allowable charges for office visits by $13.50 and would make no payments at all for lab testing. The physician could use this sum to pay for lab testing, he could pocket the entire payment and order no tests, or he could spend his own money to buy more than $13.50 worth of tests. This proposal obviously has a myriad of problems, including the fact it would unfairly force physicians to consider their own economic interest when deciding whether to order tests.

To judge the likely impact of the LRI, one need only answer the following question: Which one of us, if we were sick, would want to go to a doctor who had only $13.50 to spend for necessary testing.

[The prepared statement of Hope Foster follows:]

STATEMENT OF THE
AMERICAN CLINICAL LABORATORY ASSOCIATION

I. Introduction.

Since 1984, the American Clinical Laboratory Association ("ACLA"), an organization of federally-regulated, independent clinical laboratories has, on numerous occasions, appeared before this subcommittee to offer our views about how to help lower the federal deficit through equitable reductions in Medicare outlays for laboratory testing services. In 1984, we assisted this subcommittee in developing the Medicare laboratory fee schedule, which substantially reduced the amounts Medicare paid independent laboratories. In 1987, 1989, and 1990, we worked with the subcommittee in achieving savings by lowering the national limitation amounts that cap Medicare payment rates. In 1989, we also supported the subcommittee's efforts to restrict self-referral of Medicare laboratory testing and thereby curtail unnecessary utilization.

ACLA appears here today in the same spirit of cooperation that characterized our 1984, 1987, 1989 and 1990 efforts. We understand that we must work together to develop intelligent, mutually acceptable proposals to solve the problems that have been created by the distorted marketplace described below. ACLA welcomes this opportunity and pledges to continue the process we began so long ago. We invite the Health Care Financing Administration, the Office of Inspector General and the General Accounting Office to join us in this search. We urge other interested parties to participate in this dialogue as well.

While our commitment is unwavering, we are concerned that a number of the proposals that have been recently offered and discussed here today will create more problems than they will cure and will injure the very persons that the Medicare program was designed to protect -- the elderly and the disabled. We testify this morning to explain to you why we feel this way and to offer a solution that we believe is far preferable.

In reviewing proposals to change reimbursement, it is important to remember that laboratory testing provides a valuable service that saves money -- and minimizes pain and suffering -- through the early diagnosis and treatment of disease. President Bush's recent experience with Graves' disease graphically illustrates the indispensable contribution made by the testing services that laboratories such as ACLA members provide. Reports suggest that the President's condition could have been detected sooner -- and an expensive hospitalization might have been avoided -- had certain laboratory tests been conducted in conjunction with an earlier physical examination.

It must also be remembered that laboratory testing -- at least when performed by independent laboratories -- is truly a bargain. It is estimated that in 1990 Medicare spent only $41.91 per beneficiary for testing performed by independent laboratories. In comparison, per beneficiary expenditures for all Part B services, physicians' services, outpatient hospital care and group practice plans were $1,603.16, $1,137.82, $309.41 and $112.36, respectively.[1/]

This morning, this subcommittee has been presented with two different proposals relating to laboratories, one from the General Accounting Office ("GAO") and the other from the HHS Office of Inspector General ("OIG"). These proposals suggest widely divergent approaches to issues related to clinical laboratory reimbursement. While ACLA has not had an opportunity to analyze the GAO study which forms the basis for its conclusions, we understand that it finds that laboratories earn more on Medicare testing than on testing provided to physicians for their non-Medicare patients. This conclusion results because the GAO has identified a key structural problem in the industry, a problem that ACLA itself discussed just last year in testimony before this subcommittee. Because laboratories cannot perform testing without a doctor's order, physicians are in a position to force a laboratory to provide large discounts on non-Medicare work, which they then mark up by substantial amounts when billing patients and third-party payors.

This structural problem demands a structural solution -- implementation of a direct billing mandate that will remove physicians from their role as "brokers" of laboratory testing. As ACLA observed last year in its testimony before this subcommittee, and as suggested by the available evidence, enactment of such a requirement

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1/ Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 1991 Annual Report of the Board, at 43.

should lower the price of testing to patients and their third party payors. Medicare is an especially important insurer that will reap the benefits of such a structural solution. Thus, were a national direct billing mandate to be enacted, ACLA would be pleased to work with this subcommittee to determine how Medicare payment rates could be equitably reduced.

The OIG, on the other hand, offers a radical alternative for dealing with laboratory reimbursement, based on faulty data and inadequate analysis. In two recent reports,[2/] the OIG has suggested implementing what is, in effect, a capitated system for laboratory reimbursement, under which Medicare would pay $13.50 to a physician in connection with each office visit, which could then be used to pay for laboratory testing. This proposal has a myriad of problems, including the fact that it would force physicians to consider their own economic interests when determining whether to order tests. As this subcommittee knows from its work in the self-referral arena, physicians' treatment decisions are influenced by their economic interests. See, e.g., OIG, Financial Arrangements Between Physicians and Healthcare Businesses (1989). Indeed, this truism underlay this subcommittee's view that self-referral of laboratory testing should be barred. Yet, the LRI would pit physicians' own financial well-being against the health needs of their patients and erect incentives not to order necessary tests.

In addition, the LRI concept fails to account for differences in the practice patterns of different types of specialists or of those physicians who treat patients with more serious illnesses. Finally, the most likely result of implementation of the LRI would be impaired access for seriously ill patients -- i.e., patients needing more than $13.50 in laboratory tests. Given the grave problems that would be created by the LRI, it is not surprising that an unprecedented coalition of medical and laboratory groups recently signed a letter to HHS Secretary Louis Sullivan objecting to the proposal. A copy of that letter is attached to this statement.

In assessing the recommendations of the GAO, the OIG and ACLA, it is important to have an understanding of the current laboratory marketplace. Thus, this statement begins with a short discussion of the current state of clinical laboratory reimbursement. We then discuss the specifics of the GAO and OIG reports and our own direct billing proposal.

II. This Is Not the Time For Radical Changes in Clinical Laboratory Reimbursement.

Laboratory testing is an important, life-saving and cost-saving health care tool, which permits the early detection and treatment of a variety of conditions. Laboratory testing has been instrumental in allowing for the early diagnosis of such newly discovered diseases as AIDS and Hepatitis C. Other tests, such as therapeutic drug monitoring (TDM) assays, are used routinely to track the effects of medications prescribed for cancer and other serious illnesses. Concern about coronary heart disease has caused an increased awareness of the need to perform regular cholesterol tests and related assays for LDL and HDL.

Moreover, the early diagnosis and treatment permitted by appropriate testing ultimately saves money for all health care payors, including Medicare. For example, recent reports have indicated that a simple blood test may be more effective in detecting prostate cancer than the current methods commonly used, thereby permitting early treatment and avoiding the need for costly surgery. By leading to the early diagnosis and treatment of disease, prompt medical intervention, and consequent cost-saving, laboratory testing demonstrates its greatest value.

Since 1984, laboratories, like many provider groups, have had to confront reduced reimbursement. For example, as a result of last year's budget agreement, clinical laboratories will absorb additional cuts of $770 million over the next five years.[3/] Obviously, laboratories cannot continually suffer payment cuts without an eventual effect on quality, access or the ability to serve rural or low-volume areas. In addition, the impact of the Medicare reimbursement reductions has been intensified because labs

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2/ HHS Office of Inspector General, Ensuring Appropriate Use of Laboratory Services, A Monograph (October 1990); HHS Office of Inspector General, Impact of a Laboratory Roll-In on Medicare Expenditures: A Management Advisory Report (Dec. 1990) (draft). These Reports are summarized in the OIG's Cost Saver Handbook ("The Red Book") at E-4.

3/ Committee on Ways and Means, Overview of Entitlement Programs, ("The Green Book") at 209 (1991).

have also experienced significant escalations in their costs, many of which have been incurred since the GAO collected the data that served as the basis for its study. For example, new requirements issued by the Occupational Safety and Health Administration in February 1990 require laboratories to take additional precautions to protect workers from AIDS and Hepatitis B, including paying for workers' vaccinations against Hepatitis B. Obviously, laboratories understand the need to protect their workers from the risks associated with these diseases; however, implementing these precautions is expensive. Other new regulations, related to medical waste removal and treatment, have also added to laboratory expenditures.

Further, the laboratory industry is highly labor intensive and salaries for the skilled individuals necessary to conduct testing have grown in the last few years. Between 1985 and 1990, the average earnings of an individual employed in the health care field increased by over 32 percent.[4/] The number of individuals employed in the laboratory industry during the same period rose by almost 68 percent.[5/] Thus, laboratory labor costs have escalated dramatically over the past five years. New federal requirements that impose workload limitations in the area of cytology will only exacerbate these problems. For example, ACLA members report that in the last two years alone salaries for cytotechnologists have doubled due to these new limitations and the shortage of qualified individuals.

Finally, unlike other types of laboratories, independent clinical laboratories, such as the members of ACLA, are now subject to new, comprehensive quality assurance regulations that were issued in March, 1990 pursuant to Medicare and the Clinical Laboratory Improvement Act of 1967 ("CLIA'67"). These regulations have already required independent clinical laboratories to spend increasing amounts on regulatory compliance. Other regulations applicable to all laboratories, which implement the Clinical Laboratory Improvement Amendments of 1988 ("CLIA'88"), will, when effective, likely require further expenditures. While ACLA has long supported across-the-board, comprehensive quality assurance regulations, compliance with such regulations is costly.

In short, given the increases in costs and the decreases in reimbursement that have occurred in recent years, this simply is not the time for radical changes in the way in which clinical laboratories are reimbursed for their services.

III. The GAO Report Identifies a Key Structural Problem in the Laboratory Industry.

ACLA members cooperated with the GAO in performing a recent study of laboratory revenues and costs and supplied some of the financial information on which it is based. We have not yet analyzed the report or had an opportunity to review its conclusions. Thus, we cannot comment on the accuracy of the GAO's work or its methodology.

ACLA does note, however, that when the GAO was gathering information from the association members, several laboratories disagreed with the way in which the GAO allocated certain costs. In addition, because it is based on 1988 and 1989 data, the report fails to address a number of the cost increases, discussed above, that laboratories have incurred since that time. Thus, the GAO's conclusion that some laboratories earn more on Medicare testing than they do overall may have overstated the differences between what laboratories earn on Medicare and non-Medicare testing.

Nonetheless, the GAO has confirmed a structural problem in the laboratory industry, which ACLA itself pointed out last year in testimony before this subcommittee. This structural problem occurs because the current market system permits physicians to demand and obtain large discounts from laboratories for non-Medicare testing. Physicians then mark up these discounted prices by a substantial amount when they bill patients and third-party payors for the purchased tests. In response to the pressure to discount, many laboratories have had to charge third-party payors and patients more than doctors. Medicare, however, still enjoys a substantial discount from the prices paid by these payors.

In short, the GAO's findings demonstrate the following interplay of forces in the laboratory industry. Physicians act as brokers, paying the lowest amount for tests

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4/ Statistical Abstract of the United States, 1990 at 404; Bureau of Labor Statistics, U.S. Department of Labor, Employment and Earnings, March 1991, at 101.

5/ Statistical Abstract of the United States, 1990 at 784; Bureau of Labor Statistics, U.S. Department of Labor, Employment and Earnings, March 1991, at 55.

because they control the volume of testing. Physicians bill third-party payors and patients considerably more than the laboratory charges. Medicare pays the next lowest amount, as the government has protected itself through implementation of the fee schedules and the national limitation amounts. Finally, patients and third-party payors usually end up paying the most, either because they pay the physician's mark-up or because they bear the higher costs that laboratories are forced to pass on to offset shrinking Medicare revenues and physician discounts.

Reducing Medicare reimbursement, without addressing this basic structural problem, will only make the situation worse. It will simply force laboratories to raise prices further where they can -- to third-party payors or patients. The real solution is to remove the physician from his pivotal role in this process. Thus, the federal government should do for the private sector what it did long ago for Medicare, namely require laboratory "direct billing" to patients and third parties by prohibiting labs from billing physicians.[6/] This solution would eliminate physician mark-ups and the physician-generated price pressure on independent laboratories. Laboratories could adopt a more rational pricing system that would benefit third-party payors, patients and Medicare.

Direct billing also would have an additional salutary effect. Under the current system, physicians can earn substantial profits on each non-Medicare test that they order; thus, they also have an incentive to overutilize these testing services. Because physicians are unlikely to stop to consider who the payor is when ordering tests, the pattern of increased utilization encouraged by the current system presumably also affects the Medicare program. However, if direct billing were implemented, this incentive would be eliminated, thereby reducing utilization in both the Medicare and non-Medicare sectors. In this regard, direct billing is analogous to the 1989 Medicare self-referral prohibition that this subcommittee imposed on clinical laboratories.

Should Congress decide at some point that additional laboratory cuts are necessary, the GAO correctly observes that the appropriate way to achieve such reductions is through adjustments in the fee schedules and national limitations amounts. That is the course that Congress has chosen in the past and it, rather than the untested approach advocated by the OIG, remains the most reasonable and equitable way of achieving savings in laboratory reimbursement. However, such reductions should be coupled with the direct billing mandate for the reasons discussed above.

IV. The OIG's Proposal for LRI Implementation is Ill-Advised, Poorly Conceived and Unsupported by the OIG's Own Data.

In The Red Book, the OIG has included a proposal to "roll-in" reimbursement for laboratory services with the charge for physician office visits. OIG, The Cost Saver Handbook ("The Red Book") at E-4 (1991) (hereinafter "The Red Book"). The OIG has set out this proposal at greater length in two separate reports: Ensuring Appropriate Use of Laboratory Services: A Monograph (Oct. 1990) (hereinafter "Monograph") and Impact of A Laboratory Roll In On Medicare Expenditures: A Management Advisory Report (Dec. 1990) (hereinafter "Management Advisory Rep.") This second report has been sent to HCFA in draft form for its comments, although, to date, neither the report nor the comments have been published in final form.

The OIG proposes in these reports to eliminate separate reimbursement for laboratory testing; instead, $13.50 would be added to the reimbursement for a physician's office visit. The physician could then use this amount, if he wished, to purchase laboratory tests for his Medicare patients. If he ordered no testing, the physician would be permitted to keep the $13.50. If he ordered testing that cost less than $13.50, he would keep the difference. If he ordered testing that cost more than $13.50, he would be required to pay the excess.[7/]

There are numerous significant problems with the proposal advanced by the OIG. First, it is based on faulty assumptions. Second, it would have serious adverse effects

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6/ Several states, including Michigan, New York, Rhode Island, and California, have implemented some form of direct billing. The Congress initially considered implementing direct billing as part CLIA'88. Thus, there is ample precedent for this policy.

7/ The OIG stated in the two reports that the $13.50 LRI payment was derived by taking the $1.84 billion paid for laboratory services and dividing it by the total number of office visits, 1.37 million. Monograph at 14; Management Advisory Rep. at A-4. In fact, $1.84 billion divided by 1.37 million equals $1,343.00, not $13.50. The effect of this error on the OIG's conclusions is unclear.

not acknowledged by the OIG. Third, it does not account for the fact that some types of specialists must order more tests than others or that some physicians who treat more seriously-ill patients need to be able to order additional tests. Fourth, it would have a disastrous impact on the ability of independent clinical laboratories to provide services. Fifth, it would make it virtually impossible to enforce CLIA'88 and the Medicare self-referral ban applicable to laboratory services. And, sixth, the savings suggested by the OIG are largely illusory.

A. The OIG Fails to Consider the Reasons For Increases in Utilization or the Effect of Recent Legislation.

In its reports, the OIG focuses on increases in laboratory utilization that have occurred between 1984 and 1988. In the Red Book, the OIG notes that clinical laboratory claims account for 25 percent of the line items in Medicare claims. This is not surprising since one patient may have several different tests at one time. However, in The Red Book, the OIG fails to mention the more significant point, which it did note in its initial report; while laboratory tests account for 25 percent of the volume of Part B services, they only represent 5 percent of total Medicare Part B expenditures. Monograph at 8. In short, this fact suggests that Medicare simply receives a large number of such services at a relatively low cost.

Further, although Congress has recently enacted numerous new laws to curb inappropriate laboratory utilization, including the physician self-referral prohibition, the shell lab provision, and physician payment reform with its integral volume performance standards and clinical practice guidelines development, the OIG dismisses these as ineffective without any analysis. Finally, the OIG ignores the fact that implementation of the prospective payment system for in-patient services increased utilization of all outpatient services.

B. The LRI System Would Have Serious Adverse Effects Not Acknowledged by the OIG.

Under the OIG's LRI system, physicians would be forced to consider the financial effects on themselves of their decision to order laboratory tests. If a physician ordered tests costing more than $13.50, he would be responsible for the excess. If he ordered tests that cost less than $13.50, he would keep the difference. If he ordered no testing whatsoever, he would retain the full $13.50.

A basic understanding of human nature suggests that the LRI would cause physicians not to order necessary tests. To judge the likely impact of the LRI, one need simply answer the following questions:

— Which one of us, if we were sick, would want to go to a doctor who had only $13.50 to spend for necessary testing?

— Which one of us, if we were sick, would want to go to a doctor who could pocket $13.50 if he ordered no tests but whose return would be reduced with each test that he did order?

— Which one of us, if we were sick, would be confident that our physician would order all necessary tests knowing that as soon as the cost reached $13.50, the excess would come out of the physician's own pocket?

Most of us would be concerned about entrusting our care to even the most ethically scrupulous physician under these conditions. Yet, this is exactly what the OIG is asking Medicare beneficiaries to do.

Moreover, in addition to our knowledge of human nature, numerous studies, including one conducted by the OIG, confirm that a physician's treatment decisions are affected by his financial interest. The OIG study focused in substantial part on the laboratory field and concluded that a physician's financial interest had a "remarkable effect" on utilization. See Financial Arrangements Between Physicians and Health Care Businesses at 28. It was, of course, this study that was one of the principal bases for this subcommittee's endorsement of the 1989 self-referral prohibition for laboratories.

Yet the LRI proposed today by the OIG is simply the "flip-side" of self-referral. While self-referral gives physicians an incentive to overutilize and order too many and unnecessary laboratory tests, the LRI would provide physicians with an incentive to underutilize and order too few tests. The OIG does not explain why physicians will follow their self-interest in one case, but not in the other.[8/]

Indeed, in another context, the GAO has confirmed that the risk of underutilization is present with proposals like LRI. In 1988, at the request of the chairman of this subcommittee, the GAO studied the effect that financial incentives offered to physicians by HMOs can have on quality of care. The GAO determined that the threat to quality of care was greatest when such plans closely linked treatment decisions for individual patients to a possible financial reward for the physician. In such instances, according to the GAO, the physician had an incentive to underutilize necessary services. GAO, Physician Incentive Payments By Prepaid Health Plans Could Lower Quality of Care (Dec. 1988). Recently, in a second report on Medicare HMOs, the GAO summarized its findings:

> Many are concerned, however, that the incentives [to hold down costs] given to the participating physicians [by HMOs] pose a potential threat to the quality of care by encouraging inappropriate reductions in service. In a December, 1988 report, we argued that the more risk transferred to physicians and the more closely financial incentives are linked to decisions about individual patients, the greater the potential threat to quality.

GAO, Medicare: PRO Review Does Not Assure Quality of Care Provided By Risk HMOs. (1990) (emphasis added). As a result of these concerns, in Section 4204 of OBRA'90, Congress prohibited physician incentive payments made "as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization."

Of course, the LRI would link financial incentives directly to an individual patient and transfer all risk of treatment to the physician. Each time a physician saw a patient in his office, he would receive an additional $13.50. Any expenditures for laboratory tests that exceeded this amount would be his responsibility. Thus, according to the GAO, this type of arrangement presents the greatest threat to quality because of the risk that physicians will not order necessary tests.[9/] Without doubt, the LRI would have exactly the impact prohibited by the HMO provisions of OBRA'90.

The OIG's proposal is also flawed because physicians who wished to circumvent the LRI could simply have their patients return for additional visits. If a physician felt a patient required substantial testing that cost more than $13.50, he would have little choice but to have the patient return for additional visits. Other, less ethical physicians might have patients return for extra visits simply to earn greater revenues. Studies have shown that when physicians are offered greater financial incentives, they schedule more visits per patient to increase revenues.[10/]

Finally, the most likely -- and troubling -- result of the LRI is that more seriously-ill patients would be unable to obtain needed care. Physicians might simply refuse to take patients if they were likely to need extensive laboratory testing, because any tests costing more than $13.50 would be the doctor's responsibility. As a result, any patient who had a serious condition or, at least, one that required more than $13.50 in laboratory tests, might not be able to obtain necessary treatment.

8/ It is the presence of this self-interest element that distinguishes LRI from other programs, such as the prospective payment system for inpatient care. Under PPS, the entity that receives the payment, the hospital, is not the same entity that makes treatment decisions. These decisions are made by the physician. This separation of the treatment and payment functions protects patients. However, no such separation is present in the LRI system.

9/ In its report, the GAO stated that it was necessary to have effective quality assurance programs to avoid such problems, but the OIG suggests in its first report that such review is not worthwhile in the laboratory field because the relatively low cost of testing makes such review uneconomical. Monograph at 10.

10/ See, e.g., Physicians' Responses to Financial Incentives: Evidence From a For-Profit Ambulatory Care Center, New England Journal of Medicine, Apr. 12, 1990 at 1059.

C. The LRI Proposal Does Not Account for the Needs of Different Types of Physicians.

Under the LRI proposal, all physicians would be paid $13.50 regardless of their specialty. Of course, certain types of specialists use more tests than others. The LRI makes no allowance for the needs of these physicians, however. Although the OIG suggests that most physicians would receive enough to cover the cost of testing -- a conclusion that ACLA believes is incorrect -- the chart that serves as the basis for this conclusion does not even consider certain specialists, such as oncologists or endocrinologists, who are heavily dependent on laboratory testing. Management Advisory Rep. at A-5. Moreover, it is clear that $13.50 could not possibly cover most esoteric tests, a significant number of which cost well over $100. Yet, these tests are especially critical to those patients who need them.

The OIG argues that $13.50 would cover the cost of laboratory testing ordered by 77 percent of physicians. The Red Book at E-4. While this conclusion is subject to serious question, even if true, it means that 23 percent of physicians would not have enough money to pay for necessary testing. Thus, approximately 130,000 physicians would not have sufficient funds from Medicare to pay for necessary laboratory services.

Further, the OIG's methodology does not permit adjustments for differences in case mix. Even if the 23 percent figure were correct, which we doubt, these physicians are likely to be those treating the most seriously-ill patients. As a result, they might not have sufficient funds to pay for necessary testing services. In fact, one source cited by the OIG as having examined physician office visit "packages" comparable to the LRI observed that some type of case mix adjustment would be required. However, even after considering the likely methods for making such adjustments, the authors still rejected such physician office visits packages as unworkable. See Mitchell, Packaging Physician Services: Alternative Approaches to Medicare Price B Reimbursement, 24 Inquiry 324-343 (1987). While the OIG offers this article as support, Monograph at 16, the OIG fails to acknowledge the serious questions that the article raised about such plans.

Finally, as suggested above, the OIG's conclusion that $13.50 would cover the cost of most testing ordered is subject to serious question. The OIG has conceded that due to methodological limitations, it only analyzed data related to Medicare beneficiaries who saw one physician during the preceding year. Management Advisory Report at A-4. Accordingly, if a patient went to one physician who referred that beneficiary to a specialist who ordered additional tests, that patient was not included in the OIG's study of the impact of the LRI. Yet, many patients, and especially patients who are seriously or chronically ill, visit more than one physician during a single year. This omission suggests that the OIG's conclusion that the LRI would provide 77 percent of physicians with enough funds to cover the cost of necessary testing is seriously flawed.

D. The LRI Proposal Would Cause Consolidation of the Clinical Laboratory Industry, Deterioration in Quality and Impairment of Access.

Because the physician would only be paid $13.50 for clinical laboratory testing, if he ordered tests from independent laboratories he would likely attempt to ensure that he paid the laboratory less than this amount.[11/] Few independent clinical laboratories would be able to stay in business if they received less than $13.50 for a patient's laboratory testing. As a result, implementation of the LRI would probably force many laboratories to close or merge with other laboratories, thereby reducing the number of laboratories and increasing consolidation in the industry.

Those laboratories that did survive would either have to cut back severely to remain profitable or substantially increase non-Medicare charges. To lower costs, laboratories might have to shut facilities in rural and low volume areas, reduce service, and cut back on all non-essential programs. Indeed, the LRI would probably have the incongruous result of forcing laboratories to scrimp on quality assurance activities just at the time that CLIA'88 is supposed to cause an increase in such activities. Thus, the LRI would, in addition to causing consolidation, impair quality and curtail access.

11/ In fact, as discussed below, because of the impact of deductibles and coinsurance, the physician would in all probability try to keep the laboratory's charges below $10.80 (80% of $13.50).

E. The LRI Would Make Enforcement of CLIA'88 and the Self-Referral Prohibition Virtually Impossible.

In 1988, concerned about problems in the quality of clinical laboratory testing, Congress passed the Clinical Laboratory Improvement Amendments of 1988 ("CLIA'88"). This law requires all laboratories to meet the same stringent, quality assurance standards. As this subcommittee is well aware, HCFA has now issued four sets of proposed regulations that will, when effective, implement this vital piece of legislation.

The LRI, however, would make enforcement of CLIA'88 virtually impossible because HCFA would no longer pay laboratories for testing. For example, under regulations recently proposed by HCFA, if a laboratory failed to comply with a condition of participation, HCFA could refuse to reimburse it for Medicare testing. Since HCFA would no longer pay laboratories for testing under the LRI, however, the agency would lose this valuable enforcement mechanism. In addition, under CLIA'88, laboratories will be certified to conduct testing in certain specialties or subspecialties. If a laboratory is not certified to test in a particular area, it will not be permitted to bill Medicare for those tests. Were laboratories no longer required to submit claims to HCFA, however, the agency's ability to ensure that laboratories do not perform tests for which they are not qualified would be seriously compromised.

In addition, implementation of the LRI would also make it impossible to enforce the Medicare self-referral prohibition applicable to laboratory services which this subcommittee authored in 1989. HCFA will enforce this prohibition, in part, by ensuring that Medicare does not pay for laboratory services if the physician making the referral has a financial interest in the laboratory performing the testing. As discussed above, however, HCFA will no longer be able to monitor such claims because it will no longer be paying for laboratory services. Thus, adoption of the LRI would undercut previous congressional enactments designed to enhance quality and curtail excessive utilization and conflicts of interest.

F. The Supposed Savings Suggested by the OIG are Illusory.

The OIG projects savings of $1.1 billion in the first year of the LRI. But none of these savings are due to decreases in utilization -- the reason for the OIG's concern in the first place. Rather, these savings would result from collecting coinsurance and deductibles from beneficiaries ($980 million) and administrative savings ($143 million) stemming from the fact that carriers no longer would have to process claims for laboratory services.

Of course, Congress rejected reinstatement of beneficiary cost-sharing for laboratory services just last year for two reasons. First, the enactment of a coinsurance requirement would simply shift an additional burden onto Medicare beneficiaries, and second, coinsurance for laboratory testing would not affect utilization, as only physicians can order testing and their decisions are unaffected by enrollees' cost sharing.[12/] Both of these points were made by the Congressional Budget Office last year. See CBO, "Reducing the Deficit: Spending and Revenue Options," Feb. 14, 1990.

Moreover, application of coinsurance principles to the LRI would decrease the amount that physicians would have to pay for laboratory testing. Thus, under the OIG's plan, Medicare would allow $13.50 to the physician to be used for laboratory testing, but only $10.80 (80 percent of $13.50) would come from the program. The physician would have to go to the patient for the additional $2.70. Thus, when the physician made the decision of whether to order tests, he would know that he could only really count on $10.80, thus further diminishing his incentive to order necessary testing.

Similarly, the savings resulting from "administrative" costs suggested by the OIG are also illusory. These savings would occur simply because the government would no longer pay for laboratory tests. Obviously, "administrative" savings would accrue if any benefit payment were eliminated. Taking the OIG's logic to its ultimate conclusion, Congress should eliminate the entire Medicare program to reap the substantial "administrative" savings that will result.

12/ The Administration has re-proposed reinstatement of beneficiary cost sharing for laboratory testing services and, in The Red Book, the OIG states that enactment of this proposal "would implement the intent of the OIG recommendation [regarding LRI]." Given that enactment of cost-sharing for laboratory services does not affect utilization, however, it is hard to understand the OIG's reasoning.

Finally, the OIG suggests that in future years some savings might be realized by subjecting LRI updates to the discipline imposed by the volume performance standards. However, this savings estimate ignores the more basic question: Is $13.50, even when updated in subsequent years, enough to pay for laboratory services in the first instance?

In sum, the LRI is not simply an effort by the OIG to control utilization of laboratory services, as it suggests. By limiting each patient to $13.50 worth of laboratory tests each time he or she visits the doctor, the LRI would, in effect, implement health care rationing on a previously unimagined level. It would cause massive disruption, deterioration of quality, and curtailed access. In short, it is unfair to the physicians who order tests, the laboratories that perform them, and the beneficiaries who depend on them.

V. Conclusion

ACLA is anxious to participate with this subcommittee in addressing its concerns about the current system of clinical laboratory reimbursement. We believe, however, that it is important to find long term solutions, not just easy answers. The LRI is not the proper solution for the reasons discussed above. Wholesale slashing of the current fee schedule is also not the answer, because it will only exacerbate the problems that exist today. Federal implementation of a direct billing mandate, coupled with appropriate reductions in the Medicare fee schedules, is the most reasonable and equitable way of dealing with these concerns. We look forward to working with you to achieve that goal.

ATTACHMENT TO
TESTIMONY OF THE
AMERICAN CLINICAL LABORATORY ASSOCIATION

December 21, 1990

Louis W. Sullivan, MD
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 615F
Washington, DC 20201

Dear Dr. Sullivan:

As you may be aware, a report has been published by the Department of Health and Human Services' Inspector General titled "Ensuring Appropriate use of Laboratory Services." We are writing to inform you of our serious concerns about the conclusions expressed in this report.

The report erroneously concludes that the use of clinical laboratory services is rising too fast and that none of the constraints, controls, or mechanisms put in place by either the private sector, or Congress have worked to date, or will work in the future. The report totally ignores the benefits of these services. It then proposes an alternative of incorporating laboratory reimbursement into office visit payments as a way to curb the use of laboratory services.

We find that the study lacks a sound basis on which to propose such a radical new policy. The report is replete with errors of fact and judgment. The following points are major areas in which the report ignores or dismisses vital information and develops a preconceived thesis without anything approaching scientific methodology or validity.

1) The report includes reference to some of the many factors that may account for a growth in clinical laboratory services. It then separates them into "indigenous and exogenous" influences and goes on to dismiss the many exogenous factors (such as implementation of the prospective payment system) as being beyond the scope of the report — with a blanket statement that only the "indigenous causes can explain the inordinate growth..." — without any supporting documentation.

We are especially concerned because the study methodology appears to deliberately and inappropriately ignore valid information that bears directly on the issue at question. This is strong cause to reject the study's conclusions.

2) Although the report accurately states that utilization of laboratory services has increased in recent years, it makes a possibly unwarranted blanket assumption that this increase is inappropriate, and action must be taken to reduce it. No attempt is made to differentiate between appropriate increases that may benefit patients from inappropriate increases in the number of services.

Attempts to define appropriate levels of service are currently underway. The development of practice parameters is now widely recognized by the government and the private sector as critical to the delineation of what constitutes effective medical practice.

3) The report dismisses as ineffective current or planned activities to reduce inappropriate utilization. Although mentioning several newly legislated efforts, the report fails to support its conclusion that current Medicare initiatives to control use "may not be adequate". Medicare already has clear authority to deny coverage for inappropriate services. Since the perceived need to reduce inappropriate services by any means appears to sum up the entire hypothesis of the report, it is clear no weight or serious consideration has been given to these efforts. For example:

OBRA '89 included several provisions that may have an effect on the volume of laboratory services. A ban on physicians referring their Medicare patients to laboratories that they own will take effect in 1992. A restriction on billing for testing by so-called "shell laboratories", unless 70 percent or more is performed in house was included, as was the inclusion of clinical laboratory services in the Medicare Volume Performance Standards. Each of these recent legislative changes is disregarded and each can be expected to have an impact on the utilization of laboratory services. In this legislation Congress also chose to fundamentally change the way physicians are paid, from a charge-based system to one that recognizes the resource costs of providing services. To lump payment for services paid on a non-resource cost basis, with payments based on resource costs is inconsistent with the purpose of and incentives included in the new Resource Based Relative Value Scale system.

All of these provisions of law need time to be fully implemented and assessments of their impact made, before another new and flawed idea aimed strictly at reducing laboratory services utilization is tried.

4) Another major legislative initiative passed recently, that has yet to be implemented is the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). Final regulations implementing this statute will not be ready until the summer of 1991 — at the earliest. A great deal of uncertainty exists regarding the nature of what the final rule will look like particularly in the area of increased costs to laboratories. The cost-effectiveness and ability of laboratories to continue providing such services is unknown at this point.

This added uncertainty is one more reason it is premature to discuss a new payment based method of reducing utilization of laboratory services, especially when one considers the cumulative effect of the existing legislative and regulatory activity outlined above.

5) One final area that the report touches on is appropriate incentives for utilization of laboratory services. The report states that under a fee-for-service system, increased use of medical services is rewarded. Establishing a capitated system such as the Laboratory Roll-In concept, where the financial incentive is to provide fewer services (at a potentially inappropriate level) could jeopardize quality of care. The Laboratory Roll-In concept is inherently inequitable in that medical practice necessitates different levels of service based on the varying medical needs of individual patients/patient populations.

In fact, Congress has already spoken to the question of financial incentives and the risk of underproviding medical services with respect to managed care systems. A managed care plan cannot place an individual physician at substantial risk for services not provided by the physician unless certain stop-loss protections are also provided. In another case, in the development of Medicare Volume

Performance Standards, Congress also mandated the spread of the risk of underutilization across the physician community, as opposed to individual medical practices.

Perverse incentives such as this that could have a negative impact on access to medically necessary services should not be encouraged.

For all of these reasons, the undersigned find the report to be inadequately prepared and presented, and premature in its intent. We hope you will join us in rejecting this report's conclusions.

Sincerely,

American Academy of Family Physicians
American Academy of Neurology
American Academy of Opthamology
American Academy of Orthopaedic Surgeons
American Association of Clinical Chemistry
American Clinical Laboratory Association
American College of Chest Physicians
American College of Gastroenterology
American College of Nuclear Physicians
American College of Physicians
American College of Rheumatology
American Medical Association
American Society of Clinical Oncology
American Society of Clinical Pathologists
American Society for Gastrointestinal Endoscopy
American Society of Hematology
American Society of Internal Medicine
American Society of Microbiology
American Urological Association
College of American Pathologists
Health Industry Manufacturers Association
Renal Physicians Association
Society of Nuclear Medicine

cc: Richard Kusserow

Chairman STARK. How does that wash with the large HMOs? In fact that is what happens in the large HMO, the doctor has only a certain number of dollars a year to take care of me. So I have to trust that he will put me in the hospital if he needs to or order tests if he or she needs to.

We don't know who we do it to but I think that your argument doesn't hold for as huge a group say as the HMO. They are under a risk contract already.

Ms. FOSTER. Mr. Chairman, it is my recollection that you have expressed concern about risk-based HMO payments where incentives to underutilize services are provided to physicians.

[The following letter was subsequently received:]

acla AMERICAN CLINICAL LABORATORY ASSOCIATION 1919 Pennsylvania Ave., N.W., Suite 800, Washington, D.C. 20006/(202) 887-1400

June 14, 1991

The Honorable Fortney Stark
Chairman
Health Subcommittee
Ways and Means Committee
239 Cannon House Office Building
Washington, D.C. 20515-0509

Dear Chairman Stark:

Yesterday, as you know, I testified before your subcommittee on behalf of the American Clinical Laboratory Association (ACLA). During our discussion of the OIG's Laboratory-Roll-In (LRI) proposal, you asked me how it differed from HMO arrangements. Under the LRI, $13.50 would be added to Medicare's reimbursement for physician's office visits. No separate or additional payment would be recognized for laboratory testing services. Thus, if a physician needed more than $13.50 to pay for tests, he would have to pay for them out of his own pocket. The dangers of such a scheme are readily apparent, and ACLA' reasons for objecting to this proposal are set forth in our written statement in greater detail. Thus, I do not intend to repeat them here. However, I did want to supplement my response to the question you asked me yesterday.

The LRI would provide direct financial incentives to physicians that would affect their decisions about ordering lab tests. These incentives would be triggered on an individual patient-by-patient basis. This aspect of the LRI makes it substantially different from the HMO. First, HMOs often pay their employed physicians on a salaried basis. Thus, their compensation is unaffected by their individual decisions about what treatment is appropriate for their patients. Moreover, to the extent that HMOs award year-end bonuses to their employed physicians, these bonuses do not relate to their treatment decisions about individual patients and are therefore too diffuse to affect such decisions on an individual patient basis. In contrast, the LRI would erect <u>direct</u> incentives that would specifically affect a physician's testing decisions for each of his patients. The LRI is therefore materially different and significantly more dangerous than typical HMO arrangements.

Second, your subcommittee has expressed substantial and deserved concern about HMO plans that link treatment decisions for individual patients to financial rewards for physicians. Indeed, you enacted Section 4204 of OBRA'90 to prohibit physician incentive payments made "as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization." The GAO, in two reports, has expressed similar concerns about such payments. In our view, the LRI carries with it all of the threats to quality of care that underlay the passage of the OBRA'90 provision.

I hope that this information has been helpful. If you have further questions, I would be happy to answer them.

Sincerely yours,

Hope S. Foster

Hope S. Foster

Chairman STARK. But let's use the example of Kaiser. For example, in my home county where they don't have a direct incentive or a reverse incentive for not performing tests, it seems to work all right there.

Ms. FOSTER. I think the LRI, however, embraces incentives that would make it difficult for a physician to order tests if they cost more than $13.50 because he would personally have to pay for them from his own pocket. So I think this is somewhat different than an HMO context.

Questions can be asked here, if you were sick or if I were sick, would we want to go to a doctor who might decide to pocket the $13.50 rather than order the tests. Would we be comfortable knowing that if we needed test costing more than $13.50 maybe he would not spend it.

Chairman STARK. We don't know. We go to the doctor and if the doctor doesn't do a test we say, hooray, I am healthy. We still pay $100 for an annual physical. We are in no position to know what tests we ought to have or whether they are worth 13 cents or $13.

Ms. FOSTER. I think you are right. We can't know.

Chairman STARK. You have to trust the doctor, don't you?

Ms. FOSTER. We do. And so we should not pit the physician's interest in our health against his economic interest in making sure he has some money to take home at the end of the week.

That is the problem with this proposal. We have to trust our doctor.

Chairman STARK. That is the problem with the whole fee-for-service system. Fee for service in itself is an inherent concept. They might ask you to come back twice. See me next week.

Ms. FOSTER. I would love to. Where and when. I think that means we have to be very careful about adopting new programs which enhance that conflict of interest.

This one does in my judgment. We need to try from the laboratory standpoint to separate those financial interests, to eliminate those conflicts.

The way you do that is to try and remove the physician from having a financial stake in lab tests he doesn't perform himself. That is why we think direct billing is the right answer and why we think LRI is not the right answer.

With direct billing you could effectively and equitably reduce Medicare's payments to labs and eliminate the very conflicts we have been talking about.

Thank you.

Chairman STARK. Are you concerned that advanced technology is apt to put you out of business? In other words, it occurs to me that blood tests, let me suggest, may in time become so highly automated, computer driven that a physician can do it in his own office.

They can now if they want to take the time. Obviously, they are all doing EKGs in their own office. It has gotten to the point where the computer does them. I guess you still blow in the can to test your lung capacity. It seems to me we are going to more rapidly get to the point where just through technology, not through greed, where a doctor can do it and get the answer instantly so he will know what my cholesterol is as I sit there. It will be a question of technology not greed.

They actually do it now with the thumb prick tests but I am not sure they are so accurate. But let's assume they become accurate. A lot of this becomes moot. I am inclined to agree with you but I have a hunch that you are going to see more and more of this.

Ms. FOSTER. We are not advocating any impediment to the development of technology. We are concerned about how financial incentives drive decisionmaking and how these incentives affect the manners in which these services are provided. We think that financial incentives that create conflicts of interest should be eliminated.

Chairman STARK. Last week when I talked to your group, Ms. Parver, I encouraged you to think of new ways to approach some of these problems. I am also wondering, as I hear complaints about people saying now that the rates are changed the suppliers are going to quit the business.

I have a sympathetic ear to that. You heard me read a letter earlier. I am not inclined to find my constituents unable to get the equipment they want. Have you considered the idea of national rates? Have you discussed it or the committee discussed it, the idea of bidding? For instance, deciding what the standards should be for a wheelchair. This is the standard that Medicare will pay for, it has to have steel of such and such a gage and it has to have the chrome and tires that will last such and such a time.

These are the specs. It is the same way we buy airplanes or $600 coffee pots. Then any manufacturer who cares to meet the standards, we take a bid and any others can be in the catalog and that is what the suppliers have to buy. They can still negotiate with manufacturers, if it is a big supplier who wants to buy in quantity.

But then we know precisely what product by definition and how much we will pay. What would that do to your industry, could they live with something like that?

Ms. PARVER. Competitive bidding has worked with many industries. As far as the home medical equipment industry, there is some experience with competitive bidding in the VA hospital system. I will tell you that it has not worked very satisfactorily.

Chairman STARK. I am talking only about the hardware. A liter of oxygen is a liter of oxygen. While it may taste better in California, it is the same oxygen you breathe in Texas or New York. There are standards. They are all made the same. There are probably half a dozen suppliers of those bottles but we have standards.

Why can't we set a price for a liter of oxygen? I presume we will soon. The question of delivery is something different. Or a wheelchair, a crutch, a neckroll or whatever and we will say that is what we will pay.

We can bid each year and if some supplier has a unique manufacturing advantage they set a price. The one who splits the lowest bid gets the price.

Ms. PARVER. I think what we have to do is take into consideration the suppliers who provide the service along with the delivery of the piece of equipment. That is where you get the variation in costing. The study that you encouraged GAO to engage in over the next year will help in some of those issues.

There are variations in labor costs and other costs of doing services throughout the country.

Chairman STARK. As I suggested to you before, when I buy my Sony, which I would not buy if an American company made a comparable product, I pay the same price at Circuit City in Maryland as I would pay for Circuit City in Dublin, Calif. The only difference is in sales tax.

They will both install it and hook it up for the same price. Why shouldn't I be able to buy an oxygen bottle for the same price in those two locations?

Ms. PARVER. Because various suppliers conduct business in different ways and conduct different services.

Chairman STARK. It is the same for television. Suppose I buy it from Good Fellas in California or Uncle Jerry in New York, same cost, same delivery and installation.

Ms. PARVER. I think if you could guarantee that every single supplier performs the quality and has the same control, the assurance of that quality, has therapists on their staff who will go out and service the equipment, you can set a standard price. But where you have the variations in pricing is particularly because of the fact that the services are performed in a different way by different suppliers.

Chairman STARK. We have to deal with doctors that way. I would think removing my gall bladder is just as complex as installing a ventilating machine in my house. If I pay the same rate in Cincinnati that I paid in Malpedis why shouldn't the oxygen rate be the same?

Ms. PARVER. By 1993, you will be.

Chairman STARK. If we standardize the equipment that is delivered then it seems to me there is not a whole lot of opportunity for fraud and abuse. We say this is all we will pay.

Ms. PARVER. National pricing would help eliminate that.

Chairman STARK. We can say if you don't want this product, we don't pay for any. We don't say you can buy one with all various decorations. This is the lift seat that Medicare agrees when it is prescribed is necessary. If it doesn't match your decor, too bad.

I know that is harsh. Here are the specifications and anybody who wants to manufacture it is free to do so. They ought to come in at this point. A supplier who buys a lot of them might get a discount from the manufacturer, that is OK.

That happens now. Then these guys can advertise all night on television. My mother can buy six of them but if she doesn't buy the right one they don't get paid.

Ms. PARVER. The GAO is looking into the coverage guidelines.

Chairman STARK. Is that something you can live with?

Ms. PARVER. As a matter of fact I participated in a panel a few weeks ago on setting national uniform coverage guidelines, absolutely.

Chairman STARK. Great. I think a little simplicity in the system might be the quickest way.

Ms. PARVER. We appreciate your help in that regard.

Chairman STARK. I thank both of you. The hearing is adjourned.

[Whereupon, at 1:36 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of the American Association for Respiratory Care

The American Association for Respiratory Care (AARC), a 30,000-member professional association of respiratory care practitioners, welcomes the opportunity to submit written testimony on the Medicare Fraud and Abuse hearing held June 13, 1991. Respiratory care is an allied health specialty delivered by respiratory therapists and respiratory therapy technicians under medical direction for the assessment, care, treatment, and diagnosis of individuals suffering from diseases of the cardiopulmonary system.

As medical technology has continued to advance, some patients who would have remained in the traditional acute hospital setting can now be effectively cared for in alternate sites, such as the home or skilled nursing facilities (SNFs). The respiratory patient most often discharged into the home setting is the chronic obstructive pulmonary disease (COPD) patient. These patients usually require, at minimum, oxygen therapy which necessitates sophisticated equipment and is supported by trained and qualified personnel. These individuals possess specialized training in the monitoring and maintenance of the equipment and possess an ability to evaluate the patients condition and their need for that equipment.

The AARC is well aware of the growing cost of providing quality health care to this nation's Medicare population. The respiratory care community has maintained that, if Medicare beneficiaries in need of respiratory care have access to services provided by respiratory practitioners, there will be a decrease hospital readmissions. A previous HHS study has already documented both the dramatic hospital readmission decreases as well as the number of days spent in the acute care facility upon readmission. Furthermore, the respiratory community believes the use of trained respiratory care personnel will assure that only appropriate and necessary oxygen equipment is being delivered to the patient and paid for by the Medicare program. The AARC has proposed, and Senator Don Riegle has introduced (S 1120) a bill which would implement a demonstration project that would test the above hypotheses. During this time when Congress is faced with both budget restraints and a need to improve access to health care resources, we request that the members of the Ways and Means Health Sub-Committee will seriously consider supporting this important demonstration proposal.

Another category of patient being discharged from the hospital setting is the chronic ventilator dependent patient. While many of these patients are medically stable and could be maintained in the sub-acute care setting, such as the home or SNF, current reimbursement policies block access to the resources necessary to achieve that goal. A recent Gallup study projected that on average there were over 11,000 chronic ventilator patients per day in U.S. hospitals. It took these institutions an average of 35 days to place these ventilator patients in an alternate care setting. The Gallup survey estimated that these ventilator patients are costing the system $9 million per day to care for in the more expensive hospital setting. Many of these stable ventilator patients could be cared for in the home if qualified personnel were available to provide care.

Each year Medicare beneficiaries requiring respiratory care increase due largely to the increasing population of senior citizens. It has always been a chief concern to the AARC that current reimbursement policies and the absence of accreditation regulations fail to assure the respiratory care support these beneficiaries are receiving is adequate in terms of quality and quantity. Assurance needs to be established in order that respiratory care equipment offered by DMEs is professionally installed, monitored, and maintained. For a beneficiary, it is currently the "luck of the draw" that a DME supplier can meet their needs in providing appropriate respiratory care equipment and services. While it is true that some dealers do provide adequate levels of services and support from qualified personnel, there exists no federal requirements or mandatory standards which all must meet. The AARC applauds the efforts of the DME industry in recognizing this critical situation and its subsequent call for conditions of participation as a prerequisite to render the Medicare DME benefit.

The association has worked closely with the Joint Commission on Accreditation of Health Organizations (JCAHO) in developing its accreditation guidelines. We believe the commission's two levels of accreditation: "equipment certification" and the more comprehensive "clinical respiratory care service provider" certifications provide significant patient protections and assure that when respiratory care, a life-sustaining therapy, is rendered, it is delivered by those who are qualified to do so.

We strongly urge Congress to adopt mandatory conditions of participation based on the rigorous and proven effective JCAHO standards.

The AARC believes that the implementation of mandatory standards will explicitly address many of the problems of unethical practices within the DME industry.

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The American Society of Clinical Pathologists would like to take this opportunity to submit for the record initial comments in response to the presentation by the General Accounting Office, specifically their proposed plan for Medicare savings from reducing payments for clinical laboratory testing. While our in-depth analysis of the GAO study is not complete, we have serious concerns about the conclusion that significant cuts in Medicare payments for laboratory testing should be made since pre-selected laboratories make more profits on Medicare work than on testing provided to physicians.

ASCP is a nonprofit medical specialty society organized for education and scientific purposes. Its membership numbers more than 50,000 board-certified pathologists, other physicians, clinical scientists and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel.

As the study points out, there have been significant changes in the laboratory industry since 1988 when the data was collected. Even the Department of Health and Human Services commented that the study results should be reconsidered in view of new quality assurance requirements for laboratory testing.

We recommend in the alternative that the House Ways and Means Committee work with the laboratory community to correct an inequity in the system which permits physicians to demand and receive significant discounts, sometimes below the laboratories' actual costs of doing business. This solution is direct billing of laboratory services which will remove incentives other than patient care for the physician in ordering any clinical laboratory tests which he does not perform in his office. Similar to the "self-referral prohibition" that the Committee supported two years ago, direct billing will not only remove the significant financial incentive for ordering additional testing but will substantially reduce the need for laboratories to provide unreasonable discounts to physicians in order to stay in business.

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Final rules for hospital, independent and nursing home laboratories went into effect in 1990. The impact of these new quality assurance standards remains to be seen but clearly costs of doing business have been significantly increased. In fact, there is some evidence already that costs of providing certain testing (i.e.,cytology) under these rules may be cost prohibitive and access impeded in some areas. Implementation of CLIA '88, with the new cost of a federal certificate and inspections, will further increase the cost of providing testing services. New requirements for protection of workers from blood borne pathogens--a major concern in the clinical laboratory--are expected to be finalized by the Occupational Safety and Health Administration this year. Shortages of trained laboratory professionals also has increased laboratory testing costs over the past 3 years because of resulting increased salaries and recruitment bonuses necessary to compete for these individuals.

Also during this time period, Medicare payments for clinical laboratory testing are already scheduled to be reduced. While GAO admitted that fee schedule cap reductions in 1990 and 1991 lowered profit rates for the 5 largest and possibly the most efficient laboratories, they do not calculate the entire budget cut for laboratory testing included in the 5-yearbudget agreement which totals over $770 million less in Medicare payments to laboratories.

We are also concerned that this very limited study (only 15 from over 100,000 laboratories) found that one-third of laboratories studied (depending on case mix) were already at a rate of return on Medicare work below the laboratory's overall return on sales in 1988, prior to the above mentioned changes. This bias selection is not representative of the nation's laboratories and as such, should not be used as the bench mark for the economic adjustments.

In conclusion, we believe that the GAO study of laboratories is not representative of the majority of clinical laboratories and in view of significant reduction in payment since 1984, scheduled Medicare cuts over the next 5 years and substantial increased costs of doing business due to new regulation and legislation, the GAO's conclusions are out-of-date.

We urge you, however, to take advantage of the financial return to Medicare, from extending Medicare's direct billing mandate to all payers.

Statement of the

Federation of Podiatric Medical Boards
PO Box 33285 Washington, DC 20033
(202) 659-3112

submitted for the written record in conjunction with hearings held by the

House Ways and Means Subcommittee on Health
June 13, 1991 - Medicare Fraud, Waste and Abuse

Mr. Chairman and Members of the Subcommittee:

I am Tony Butera, DPM, President of the Federation of Podiatric Medical Boards, and podiatrist member of the Virginia Board of Medicine. I appreciate the opportunity to submit a statement for the record for our organization, which represents the state licensing boards for podiatric medicine. Through the Federation, individual state boards are able to undertake projects for the common good.

Cooperation: Beginning in 1987 the Federation and the Office of the Inspector General began to coordinate efforts in a number of areas. We now share with DHHS information on state board findings of fact and actions taken against podiatrist license holders, and in turn we receive information on DHHS/OIG disciplinary sanctions.

Enforcement: This exchange has had an extraordinary and positive impact. It has enhanced state board enforcement of medical practice statutes. There is little if any cost to the Federal government; the printing and mailing of DHHS summaries in our reports to our membership is paid for by the dues we collect from state boards themselves. By using up-to-date personal computer technology, our reporting transmittal system is efficient, accurate and cost effective. While we do not purport to cover all the bases that the National Practitioner Data Bank encompasses, we believe our administrative approach might even serve as a model and alternative to the disciplinary data exchange program mandated by PL 99-660.

Full participation needed now: You can help us greatly in one important respect. Moreover, no Federal dollars are involved. A very few state governments (the ***District of Columbia, South Dakota, Utah, Vermont, and Wisconsin***) have the notion that it makes sense to save a few hundred dollars by preventing their state boards from participating in these exchanges. These states bar dues payments to organizations such as ours. In effect, these few states leave it up to others to pay the freight for this useful collective effort. Perhaps Congress can help dramatize what a false economy non-participation is. We would point out that hundreds and thousands of dollars - not millions and billions - are involved, but these dollars are spent in a way so as to foster effective and meaningful cooperation between the states and the Federal Government.

Statement of the Home Care Coalition

The Home Care Coalition supports the efforts of Congress, the Health Care Financing Administration and the General Accounting Office to identify and focus resources to combat abusive and wasteful practices affecting the home medical equipment and long term care supplies benefit. Often such practices result from unnecessary complexities of the Medicare program, particularly the administration of the home medical equipment benefit.

While we support the need to eliminate the opportunity for abusive and wasteful practices, we are concerned that Congressional, HCFA and OIG action be targeted to address the abuse and not adversely impact the ability of Medicare beneficiaries to receive timely and quality home medical equipment (HME) services.

In the past, Congressional solutions to real or perceived problems have created difficulties of their own. For example, the modality-neutral method of oxygen payment reform enacted in the Omnibus Budget Reconciliation Act of 1987 has had a demonstrable impact reducing the availability of portable liquid oxygen. Similarly, the broad payment reform for wheelchairs in the Omnibus Budget Reconciliation Act of 1990 appears to be reducing the beneficary's ability to receive these items in a timely manner.

The existing support services that are incorporated into the Medicare home medical equipment services benefit are absolutely essential to assure the timely availability of quality HME services. These support services range from timely delivery, set-up, and education for the beneficiary and family; to technical, logistical and paperwork support for the hospital discharge planner and prescribing physician; to the supplier's availability in inventory of the wide variety of products patients need in the home.

A recently released report on cost-effectiveness of home medical equipment services underscores the need for Congress to strengthen the availability of necessary HME services. In a study entitled "Economic Analysis Of Home Medical Equipment Services," (May 1991) Lewin/ICF analyzed three case examples: hip fracture, Amyotrophic Lateral Sclerosis (ALS) with pneumonia, and Chronic Obstructive Pulmonary Disease (COPD). Lewin/ICF concluded that savings up to $2,330 per patient episode could be achieved, with annual savings potential of up to $575 million, when home medical equipment is used in conjunction with inpatient hospital treatment.

American Federation of Home Health Agencies

American Association for Continuity of Care

American Association for Respiratory Care

American Physical Therapy Association

Emphysema Anonymous

Help For Incontinent People

Health Industry Distributors Association

Health Industry Manufacturers Association

National Association of Medical Equipment Suppliers

National Association of Retail Druggists

National Easter Seal Society

United Ostomy Association

Visiting Nurse Associations of America

HOME CARE COALITION MISSION STATEMENT:

"The mission of the Coalition to Support Quality Home Medical Equipment, Supplies and Services is to preserve the Medicare durable medical equipment benefit, to support quality home medical equipment, supplies and services, and to improve access to these services. The primary goals of the Coalition will be those which focus on education and communication directed to its members, policy makers and the public. In meeting its goals, the Coalition will contribute to the well being of home care patients, will advance the concept of home care as a vital component of a cost effective health care delivery system, and will improve access to home care services."

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ISBN 0-16-037758-7
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